MEDICARE HMO ENROLLMENT GROWTH AND PAYMENT POLICIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

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MEDICARE HMO ENROLLMENT GROWTH AND PAYMENT POLICIES

WEDNESDAY, MAY 24, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:08 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
May 9, 1995
No. HL-11

CONTACT: (202) 225-3943

Thomas Announces Hearings on Increasing and Improving Options for Medicare Beneficiaries

-- Private-Sector Lessons to be Sought --

Congressman Bill Thomas (R-CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a series of hearings to explore increasing and improving options for Medicare beneficiaries, with a focus on private-sector successes.

The hearing dates and subjects are as follows:

Tuesday, May 16, 1995:	**Experience in Controlling Costs and Improving Quality in Employer-Based Plans**
Wednesday, May 24, 1995:	**Medicare HMO Enrollment Growth and Payment Policies**
Thursday, May 25, 1995:	**The Potential Role for Employers, Associations, and Medical Savings Accounts in the Medicare Program**

The hearings on May 16 and May 24, will be held in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. The hearing on May 25 will be held in room B-318 of the Rayburn House Office Building, beginning at 10:00 a.m.

Oral testimony at these hearings will be heard from invited witnesses only. Witnesses will include health policy experts, representatives from the health care industry, and employer groups. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee or for inclusion in the printed record of the hearing.

BACKGROUND:

According to the 1995 report of the Board of Trustees, the outlays of the Medicare Hospital Insurance (HI) trust fund will exceed income beginning in 1996 and the HI trust fund is projected to run out of reserves in 2002, using the intermediate set of assumptions.

To keep the HI trust fund in actuarial balance for 25 years would require, in the absence of spending restraints, an immediate 44 percent increase in the payroll tax rate. As a result, taxes on a person earning $20,000 would be increased by $260 annually and a person earning $30,000 per year would see their taxes hiked by $390 a year. Those who make $75,000 a year would pay an additional $975 in taxes every year.

In the report, the Board of Trustees called for "prompt, effective, and decisive action" to put the HI trust fund into balance.

(MORE)

The Board of Trustees also expressed "great concern" about spending growth from the Supplementary Medical Insurance trust fund. As noted by the Board of Trustees in the 1995 report:

> "In spite of evidence of somewhat slower growth rates in the recent past, overall, the past growth rates have been rapid, and the future growth rates are projected to increase above those of the recent past. Growth rates have been so rapid that outlays of the program have increased 53 percent in the aggregate and 40 percent per enrollee in the last 5 years."

Medicare insurance coverage remains largely as it was originally enacted in 1965: traditional fee-for-service indemnity insurance with beneficiary cost-sharing requirements to control utilization.

However, private health insurance has evolved substantially since that time. More and more privately insured Americans are enrolled in managed-care plans, such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations. According to the Group Health Association of America (GHAA), some 56 million Americans were enrolled in HMOs in 1994, up from 36 million in 1990, and 65 percent of people with employer-based health insurance plans were enrolled in some form of managed-care arrangement, according to the KPMG Peat Marwick Health Benefits in 1994 (October 1994).

Moreover, managed-care organizations have recently been successful in slowing the rate of growth of premiums. In 1995, on average, HMOs are expected to reduce their per person premiums by 1.2 percent, according to GHAA.

Some private employers have also begun to offer their employees Medical Savings Accounts. Such accounts allow employees and their dependents to control their health care dollars, providing strong incentives for cost conscious spending.

Medicare beneficiaries can enroll in HMOs under the risk contracting program and other managed-care arrangements, but, due to certain features of the program, managed-care remains a relatively small part of Medicare, with only 8 percent of the beneficiaries enrolled in managed-care plans as of December 1994. Medicare beneficiaries are also not currently able to enroll in any kind of Medical Savings Account.

FOCUS OF THE HEARINGS:

The hearings will focus on successful private-sector approaches at controlling costs and improving quality and an exploration of how such approaches can be made more available to increase choices for Medicare beneficiaries.

The hearing on Tuesday, May 16, 1995, on "Experience in Controlling Costs and Improving Quality in Employer-Based Plans" will review the approaches employers have taken to improve the cost-effectiveness and quality of their coverage for their employees, the issues and problems encountered as these approaches were implemented, the effectiveness of these approaches, and lessons the Federal Government can learn from these private-sector experiences.

The hearing on Wednesday, May 24, 1995, on "Medicare HMO Enrollment Growth and Payment Policies" will investigate the reasons for increasing beneficiary enrollment in Medicare risk contracting HMOs, and current and alternative HMO payment methods.

The hearing on Thursday, May 25, 1995, on "The Potential Role for Employers, Associations, and Medical Savings Accounts in the Medicare Program" will explore issues involved in enabling employers and associations to offer Medicare coverage to former employees and members, respectively, and the potential role Medical Savings Accounts could play in the Medicare program.

(MORE)

WAYS AND MEANS SUBCOMMITTEE ON HEALTH
PAGE THREE

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Thursday, June 8, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

*****

Chairman THOMAS. The Subcommittee will come to order.

I want to welcome you to our hearing on Medicare's HMO Program. This morning, we are going to hear from a number of panels to allow us to begin to focus on an effort to make Medicare better by improving the solvency of the trust funds and by examining ways to provide more options to the beneficiaries for their health care coverage outside of the traditional program.

Clearly, one of the options among many beneficiaries will be the enrollment in cost effective HMOs. Today we will examine the current Medicare HMO Program, the recent enrollment growth, current policies for paying HMOs under risk contracts and, obviously, options for modifying the payment system.

In April, 1993, 1.6 million Medicare beneficiaries were enrolled in HMOs with risk contracts. In April of this year, there were 2.5 million beneficiaries in such plans, a 56-percent increase in just 2 years. All signs indicate that enrollment will increase another 20 to 25 percent this year.

Clearly, coordinated care is making some inroads into the Medicare Program. Beneficiaries are finding that in many parts of the country, well-run private health plans can provide more coverage at less cost than the traditional Medicare Program. By enrolling in risk-contracting HMOs, they can reduce their Medigap premiums and, to a certain extent, their paperwork hassles.

Nonetheless, managed care remains a relatively small part of Medicare, with only 9 percent of beneficiaries enrolled in coordinated care plans; and the payment methodology for risk contracts, which is essentially a fee-for-service shadow price, has been criticized by many as arbitrary and really ineffective in reducing costs for the program.

I am anxious to hear from the list of experts we have testifying today about how we might move away from the current payment methodology, the so-called AAPCC, or the average area per capita cost payment structure, to a payment system that promotes cost effectiveness, is more stable geographically, and encourages more plans to offer coverage to more Medicare beneficiaries.

I am also pleased that we have a sufficient number of witnesses from Arizona to take more of an indepth look at that particular HMO market. Arizona is a highly competitive market. Well-coordinated care organizations have been very successful in enrolling large numbers of Medicare beneficiaries, even though the payment rates are not as high as other areas with managed care enrollment rates that are high as well. I am grateful that the three HMO representatives from Arizona are here today and are going to share their insights with us.

These HMOs differ in terms of their evolution, size, and approaches to managed care. So their particular perspective is something that we want to get on the record in the hopes of finding some common patterns that will assist us in this evolutionary process.

I look forward to hearing from all our witnesses, but prior to that, I would recognize the Ranking Minority Member, Mr. Stark, for his opening statement.

Mr. STARK. Thank you, Mr. Chairman.

We are going to talk about managed care today and how to improve managed care for Medicare's beneficiaries. I think we have got to deal with three things. Does managed care actually save us any money? If one assumes that managed care restricts the use of health care services, does that serve the patients well? And, in general, how have managed care plans been working for the Medicare population?

CBO has consistently reported that the savings from managed care are pretty elusive. It only works generally with staff model and group model HMOs. You only get savings from those. There is little evidence that managed care reduces any growth in health spending over a period of time, and virtually all of the recent growth and enrollment in managed care plans has been in looser arrangements, such as preferred provider, point-of-service plans, those which have no evidence of saving any money.

The issue of consumer satisfaction, I find that studies which tend to show people who like fee-for-service don't really reflect whether or not we save money or not, and I tend to dismiss those; but my own district experience is that half of my constituents belong to the Kaiser Permanente Health Plan and they seem to be satisfied. A large number of them choose to stay in Kaiser when they mature into Medicare. And yet, I receive a lot of mail from people who are unhappy. The stories are anecdotal, but they largely have to do with restricted or withheld care.

Managed care options have worked reasonably well, but we know that the AAPCC payment system needs fixing. This Subcommittee made that clear in legislation we approved in 1989. Wide variations in payments to HMOs make little or no sense, and they leave the impression that access to low-premium, high-benefit HMOs may be an act of where the beneficiary lives, rather than a function of the particular health plan.

To devise a fair payment system is going to be a real problem. The potential for risk selection within the Medicare population is high. The citizens are uniquely vulnerable in that population, and it provides an opportunity for health plans, usually through unscrupulous insurance salesmen, to skim off the low-risk beneficiaries; and proposals to increase managed care enrollment of that nature could cost Medicare more, not less.

So last, I think that we have to preserve managed care's voluntary nature. My feeling is that efforts to coerce beneficiaries to enroll in HMOs or other managed care organizations will cause problems and eventually end in failure.

Taking away the freedom of choice of doctors and hospitals from the Nation's seniors, to me, is a sure way to start a revolution. No amount of planning can take away the fact that the choice of a plan is not the same thing as the choice of a doctor, and I think if we keep that in mind, we may avoid a lot of problems that we have had in the past when we have legislated too quickly for seniors.

We could provide new profit centers for insurance companies, but that is not what this Committee ought to be doing. We can find ways to cut Medicare benefits, but I am sure that the public will call that to our attention, and I think we have to continue to protect the benefits that seniors receive and do that incrementally.

I don't think there is a quick fix out there. We looked for it on a bipartisan basis for 10 years and didn't find one. I am sure we will have some suggestions. I don't know if we have got anybody from Jackson Hole, but I am sure that oxygen starvation still prevails in that group, and they will have some kind of a quick fix, but we will see. I think we could just keep doing what the Chairman has done so well and move slowly and cautiously.

I look forward to the witnesses that you have assembled today. Thank you.

Chairman THOMAS. I thank the gentleman for his opening statement, notwithstanding all of those cautionary and sometimes wise observations. We have got the Medicare Hospital Insurance Trust Fund going bankrupt, and I am looking for any and all options.

Our first panel is Gail Wilensky, who is the new Chairperson of the Physician Payment Review Commission. I believe this is the first time she will be appearing before us in that particular capacity. We also have Stuart Altman, Chairman of the Prospective Payment Assessment Commission; and Jonathan Ratner, who is Associate Director in the U.S. General Accounting Office in the area of Health Financing Issues.

I would tell each of the panel members that any written testimony that they may have will be made a part of the record, without objection, and that you may proceed to inform us in any way you believe will be useful in educating us.

And we will start with Dr. Wilensky and then move to Dr. Altman and Mr. Ratner. Dr. Wilensky, again, congratulations, and welcome to the Subcommittee.

STATEMENT OF GAIL R. WILENSKY, PH.D., CHAIR, PHYSICIAN PAYMENT REVIEW COMMISSION

Ms. WILENSKY. Thank you, Mr. Chairman. I appreciate this opportunity to be here to present the Physician Payment Review Commission's views concerning Medicare managed care.

The Commission, as you know, has devoted considerable thought to this important issue in its 1995 annual report, and it has made recommendations on some needed improvements in the payment policies. We are also beginning to work on several projects that will provide the Congress with information we hope will be helpful in extending the role of Medicare managed care.

As we speak, U.S. health care is undergoing major changes. Employers are fundamentally changing the way that they purchase health care services, and managed care plans are growing rapidly and evolving toward integrated systems of care. Hospitals and physicians are joining together in new types of organizations, which are transforming the way that care is being delivered.

These developments, along with the financial pressures that face the Medicare Program, as you know only too well, are bringing Medicare to an important juncture. Dynamic change in the marketplace is creating both opportunities and challenges to the Congress to improve the performance of the Medicare Program and to further such policy goals as containing costs, expanding access, and ensuring quality of care. While the innovations in the private sector suggest new solutions to longstanding policy problems, the pace of change varies widely around the country. Multiple approaches

and policy responses will be needed to reinforce the positive effects of these market changes.

Although managed care remains a small part of Medicare, its rapid growth does suggest that the time may be ripe for policy changes that will help guide this program into the next century. Much can be done to make changes in Medicare that are consistent with the innovations that are going on in the private sector and to ensure that the program acts as a prudent purchaser in responding to the changing health care environment. The challenge that lies ahead will be to expand the number of choices available to beneficiaries and encourage the use of cost effective providers, and to do so in ways that protect the fiscal integrity of the program and also, of course, preserve the beneficiary's access to high-quality care.

I would like to provide some background information on what has been going on, but more importantly, to talk about some of the changes that are needed in payment policy. And I will also outline very briefly some of the work that is going on now to try to help this Committee as it develops a Medicare reform package.

As you well know, beneficiaries can choose HMO enrollment when they become Medicare eligible or at other times when HMOs offer open enrollment. As the health care system has moved toward managed care and integrated delivery systems, the willingness of HMOs to participate in Medicare and the beneficiary enrollment has grown rapidly, although it still remains a very small part of the program. We should note, however, that about three-quarters of the elderly live in an area where there is a Medicare managed care plan available to them.

Enrollment rates vary considerably across the country as you have mentioned, but there are high rates that tend to occur in some areas where there is very high commercial HMO penetration. We may be able to learn something about the growth in those areas.

Further expansion will depend on a number of factors: The capacity of HMOs to accommodate elderly and disabled patients, the willingness of the plans to do business with the program, and of course, the willingness of the elderly to receive care under these arrangements.

The ability of a plan to attract and retain the elderly will grow over time as people who are now in managed care plans age into the Medicare Program. At the same time, Medicare can encourage greater plan participation and also ensure that cost savings achieved occur as a result of efficiencies rather than by risk selection.

Changes in the payment methodology are urgently needed and these need to be considered as a first step in encouraging a more substantial role for managed care. The Commission, in its 1995 report, has made a number of recommendations which we believe would enhance the program performance. There are a number of problems now about the way that Medicare payment occurs to HMOs, and it has contributed to the limited participation.

These problems include linking the managed care payment to the Medicare fee-for-service expenditures in the area and the very wide geographic variation in terms of the amount that is paid. They in-

clude the highly volatile county-level payment rates, particularly those with small Medicare populations. They include an inadequate risk adjustment mechanism, and also the unrestricted movement between risk and cost contracts which results in HMOs with risk contracts attracting patients with less expensive patterns of care.

In the Commission's view, the first step toward expanding managed care should be improving the payment policy for risk contracts by correcting the flaws in the current program, and that means correcting the flaws in the AAPCC. There are at least two approaches to improving the capitation payments: A competitive bidding mechanism and, also, refining the current AAPCC, because we won't be able to have competitive bidding early on in all areas. That is, because there are just not enough HMOs in some areas, both approaches will be needed.

We also need to make payment adjustments that mitigate the financial impact of adverse risk selection. Because my written testimony provides some information about how we see competitive bidding occur, I would just like to indicate that we believe that it will have to generally occur by having the plan submit offers of minimum payment rates that they would be willing to take and give HCFA the ability to establish a payment rate that is based on the bids submitted and to make sure that there are some penalties for those plans that try to have high bids in there to protect themselves.

HCFA needs to be given sufficient authority and flexibility to introduce a competitive bidding process in those markets where they have the best chances for success and then to expand the competitive bid process as they learn from those activities. But as I have indicated, we have to recognize that the AAPCC will continue to be used in some areas because there won't, at least early on, be enough HMOs to permit competitive bidding; and that means we need to make some adjustments to some of the flaws that are there.

Right now what happens is that the ratio of the county-level per capita costs are taken relative to the national average. It is flawed because it provides very unstable rates over time that are susceptible to extreme geographic variations and service use patterns. It also encourages HMOs to go into the areas that have very high expenditure per capita.

We need to recognize that input prices can vary and those are factors HMOs can't control, but we need to protect ourselves from incorporating the effects of the very high service rates which now occur.

All of these changes are currently affecting the AAPCC. A blended AAPCC, one which uses a weighted average of the AAPCC and the national average per capita, the so-called USPCC, adjusted for local differences in prices, would be a way to make that kind of adjustment, still taking account of some local variations, but not automatically incorporating all the high use that may occur.

To reduce payment volatility, there are at least two approaches that could be used. One is to define a larger geographic area and the other is to use a statistical technique that establishes county-level payment rates that are based partly on the county's average payment and partly on the payment rate for a larger area. There

are also such things as partial capitation that would use a blended rate of the average of the capitation payment and fee-for-service payments; and also we could consider having something like a risk corridor that would adjust capitation to an HMO's net financial gains or losses exceeding some established threshold.

Because these are new ideas, we would suggest you think about some demonstrations for using these partial capitation rates before extending them to the whole Medicare Program.

There is also an issue with regard to the enrollment policy. Now, as you know, people can opt in and opt out on a 30-day basis and that may contribute to risk selection. The Commission suggests that a more structured enrollment process be considered that provides for a more coordinated open enrollment period and also, importantly, furnishes the elderly with information so that they can make comparisons about the choices that they would have available. Choices are good, but information to make wise choices are crucial.

I think you should also reconsider the use of the cost contract, particularly in areas where you consider using competitive bidding. That invites increased spending in Medicare and also risk selection.

There are a number of areas where the Commission is now working to try to provide information that we hope will be helpful to you. Let me just summarize those quickly.

One is further work to set the capitation payment rates for the risk contracting programs, to identify potential markets where competitive bidding would be feasible, to design a bidding process, to structure the premiums for high bidders, and to consider how to establish payment rates in areas where we know competitive bidding just won't be able to work.

The Commission is also updating its assessment of current risk adjustment methods. We all know that this has been one of the major problems confronting the increased use of managed care in Medicare, and of course, in the private sector it is also a problem.

We would like to explore more structured choices for Medicare beneficiaries. The questions of interest here include whether or not financial incentives for the elderly to choose more cost effective plans could be made available and how exactly you would structure these incentives. Options and information are important, but without the use of incentives, we shouldn't fool ourselves that there will be enormous amounts of change in the Medicare Program.

We need to look at statutory barriers that also may be inhibiting managed care growth and figure out how to manage better the fee-for-service sector of Medicare, which we understand will always exist in the future.

Access to care for the elderly will be a continuing issue of interest. We need to be sure that we are monitoring access, for both those that are enrolled in managed care programs and those that are enrolled in fee-for-service. And also, finally, with respect to graduate medical education, we need to consider whether or not the payments that are now going to HMOs for expenses related to graduate medical education make sense and if there needs to be a modification, what that should be.

The Commission is focused on improving the methods of paying HMOs, and changing these methods is long overdue. We just have to remember, it is only one element in making reforms to the Medicare Program. Medicare can remain the last open-ended program dominated by fee-for-service medicine and unrestricted choice of providers; or it can follow the kinds of changes that are going on in the market in terms of the choices that it offers the seniors. We need to remember that when Medicare was first set up in 1965, it was modeled after the program primarily in existence in 1965, Blue Cross-Blue Shield. I think it is appropriate to now look at the changes that are going on in the medical marketplace and make changes in Medicare that reflect this continuing evolution.

I would be glad to answer any questions that you may have. Thank you.

[The prepared statement follows:]

TESTIMONY OF GAIL R. WILENSKY, PH.D., CHAIR
PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. Chairman, I appreciate the opportunity to be here this morning to present the Physician Payment Review Commission's views concerning Medicare managed care. The Commission has devoted considerable thought to this important issue in its 1995 Annual Report, making recommendations on needed improvements in Medicare's payment policies for managed-care plans. In addition, we are now beginning work on several projects that will provide the Congress with information it can use to extend the role of managed care within the Medicare program.

As we speak, the U.S. health care system is undergoing a major change. Employers are fundamentally altering the way they purchase health services. Managed-care plans are growing rapidly and evolving toward more integrated systems of care. Physicians and hospitals are joining together in new types of organizations, transforming the way care is delivered.

These developments, along with the financial pressures facing the Medicare program, are bringing Medicare to a turning point. Dynamic change in the marketplace is creating both opportunities and challenges for the Congress to improve performance of the Medicare program and to further such policy goals as containing costs, expanding access, and ensuring quality of care. While the innovations in the private sector suggest new solutions to longstanding policy problems, the pace of change varies widely around the country. Multiple approaches and policy responses will be needed to reinforce the positive effects of market evolution and to mitigate any adverse consequences.

Although managed care is now only a small part of Medicare, its recent rapid growth suggests that the time may be ripe for policy changes that will guide the program into the next century. Much can be done to make changes in Medicare consistent with innovations in the private sector, and to ensure that the program acts as a prudent purchaser in responding to the changing health care marketplace. The challenge that lies ahead will be to expand the number of choices available to beneficiaries and encourage the use of cost-effective providers, and to do so in ways that protect the fiscal integrity of the program and preserve beneficiaries' access to high-quality care.

In my testimony this morning, I will provide some background information on the current role of managed care within the Medicare program and then present the Commission's recent recommendations on changes needed in Medicare payment policies. I will also outline the work that is getting underway which we hope will be of assistance to you as you develop a Medicare reform package.

The Context for Change

Under the provisions of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Medicare beneficiaries have the option to enroll in health maintenance organizations (HMOs), all of which offer Medicare-covered benefits and most of which also offer coverage of cost sharing and supplemental services that replaces Medigap policies. Beneficiaries may choose HMO enrollment when they become Medicare eligible or at other times when Medicare HMOs offer open enrollment.

As the health system has moved toward managed care and integrated delivery systems, both the willingness of HMOs to participate in the Medicare program and beneficiary enrollment in these plans have grown rapidly. The number of managed-care plans with Medicare risk contracts increased by over 80 percent from the end of calendar year 1990 to the end of calendar year 1994, and enrollment increased by about 85 percent during the past 5 years. Currently about 9 percent of Medicare beneficiaries are enrolled in HMOs. About 75 percent of enrollees are in HMOs with risk contracts which are paid on a per capita basis; the rest are in plans with cost contracts that are paid based on "reasonable costs."

Fully three quarters (74 percent) of Medicare beneficiaries now live in an area with a Medicare managed care plan available to them. But enrollment rates vary considerably across the country, with higher rates tending to occur in areas where commercial HMO penetration is high. Almost one-third (28 percent) of those Medicare beneficiaries living in California and Arizona are enrolled in risk contract HMOs. By comparison, 15 percent of those in Florida receive care

from HMOs and just 5 percent of those in Massachusetts and Texas. There are virtually no Medicare HMO enrollees in 28 states.

Policy Responses

Further expansion of managed care within the Medicare program will depend upon several factors: the capacity of HMOs to accommodate elderly and disabled patients, plans' willingness to do business with the program, and beneficiaries' willingness to receive care under these arrangements. Plans' ability to attract and retain Medicare beneficiaries and beneficiaries' comfort level with managed care will likely grow over time. At the same time, Medicare could encourage greater plan participation and ensure that the cost savings achieved as a result of managed care efficiencies accrue to the Medicare program by reforming its methods for paying HMOs.

Changes in this methodology are urgently needed and should be considered a first step in encouraging a more substantial role for managed care within Medicare. The Commission has made a number of recommendations in this area which would enhance program performance and help Medicare capitalize on innovative changes in the health care market.

The Problem. Current Medicare payment policies for HMOs are fundamentally flawed, and have contributed to problems of limited HMO participation (and thus low beneficiary enrollment rates), and higher costs per enrollee than their fee-for-service costs would have been. These problems include:

- the linking of managed care payment rates to Medicare fee-for-service expenditures, so that the cost efficiencies achieved by HMOs do not result in savings for Medicare;
- wide geographic variation in payment rates due to local variations in fee-for-service patterns of use;
- highly volatile county-level payment rates, particularly for those with small Medicare populations;
- inadequate risk adjustment methods; and
- unrestricted movement between risk and cost contracts, resulting in HMOs with risk contracts attracting patients with less expensive patterns of use.

The Solutions. In the Commission's view, the first step in expanding managed care should be improving payment policy for risk contracts by correcting flaws in current capitation rates (referred to as adjusted average per capita costs or AAPCCs). If Congress fails to address these problems, a greater role for managed care will not necessarily lead to cost savings. Building upon this foundation, additional managed care choices (such as Medicare SELECT and other preferred provider or point-of-service options) also can be expanded. In addition, other approaches that would create competition among fee-for-service and managed care options within Medicare should be explored.

Capitation payment rates should be improved so that they (1) cover costs of an efficient HMO, (2) are better adjusted for risk selection, and (3) are more predictable from year to year. The Commission suggests two approaches for improving capitation payments: competitive pricing methods and refinements to the current AAPCC geographic adjustment method. Because competitive pricing would be effective only in markets with multiple HMOs, both approaches are needed in the short-term.

Also needed are payment adjustments that mitigate the financial impact of adverse risk selection (having a patient population with higher than average health care use) and reduce the incentives for HMOs to select good risks. Since current risk adjustment methods are inadequate, partial

capitation methods that base HMO payment partly on a capitation rate and partly on actual experience could also be tested. Reconsideration of the 30-day enrollment policy should also occur. These are discussed below.

Competitive Pricing. Competitive pricing would uncouple HMO payment rates from expenditures in the fee-for-service sector, using market mechanisms to establish payments that reflect the costs for an efficient HMO. The process could work as follows. First, HMOs meeting the qualifying conditions for risk contracts would submit offers of the minimum payment rate they would be willing to take. Then the Health Care Financing Administration (HCFA) would establish a payment rate based on the bids submitted. To create incentives for plans to bid low, plans that bid higher than the final rate should be penalized, perhaps by requiring these plans to charge the balance of their bid to beneficiaries in the form of premiums.

Whether Medicare would save money from using competitive bidding would depend upon how the final payment rates established from the bidding process compare with the level of the AAPCCs in those markets. Because it is not clear how competitive bidding might affect Medicare costs, some have proposed using payment limits -- for example, using the national average per capita cost, adjusted for local input prices, as an upper limit. This approach is not ideal, however, because it would reintroduce the very problems that competitive pricing was intended to correct and distort competition by preventing the established price from reflecting local market conditions.

To enhance prospects for successful implementation, the Commission recommends that HCFA be given sufficient authority and flexibility to introduce competitive bidding in markets with the best chances for success (e.g., those with high HMO penetration) and gradually increase the number of markets as competitive conditions change.

Refinements to the AAPCC Geographic Adjustment Method. Because competitive pricing would be effective only in markets where multiple plans can compete for Medicare business, AAPCCs or some other form of administered payment rates will be needed for the foreseeable future. AAPCCs also might be used during an interim period in locations designated for competitive pricing, until the new method was ready to implement.

Adjustments are currently made for differences in costs across geographic areas by taking the ratio of county-level per capita costs to the national average. This method is flawed because it establishes payment rates that are unstable over time and are susceptible to extreme geographic variation in service use patterns. It also creates an incentive for HMOs to choose to serve those counties within their service area with the highest payment rates.

Theoretically, geographic variation could be addressed by making payment adjustments that recognize input price factors that HMOs cannot control, such as local wage rates, and the portion of service use variation that is attributable to differences in health status. The current AAPCC reflects all service use variation, a portion of which reflects service underuse or overuse, and we are not able to measure the individual components accurately. Until more direct measures are developed, the Commission has recommended that a blended AAPCC be used, which is a weighted average of the AAPCC and the national average per capita cost (USPCC) adjusted for local differences in input prices.

To reduce payment volatility, two possible approaches are suggested. The first is to define geographic areas with larger Medicare populations, to obtain a more stable base of health care expenditures for calculating AAPCCs. The second is to use a statistical technique (called a shrinkage estimator) to establish county-level payment rates that are based partly on the county's AAPCC and partly on the payment rate for a larger area that contains the county.

Partial Capitation. When an HMO assumes full risk for its enrollees' health care costs under capitation, its financial results could range widely from large gains to large losses. Partial capitation would minimize these potential swings by having Medicare share risk with HMOs that had losses or gains outside specified thresholds. Two different partial capitation methods could

be used (1) blended rates based on a weighted average of a capitation payment and fee-for-service payment for actual health care services provided, using existing Medicare fees, and (2) risk corridor payments that would adjust capitation rates in proportion to an HMO's net financial gains or losses exceeding established thresholds.

Although this is a promising solution, partial capitation could be difficult to administer. Before this method is widely used, therefore, demonstrations are needed to test different models and their data requirements for HMOs, and to develop needed information for setting risk thresholds and risk sharing percentages.

Enrollment Policy. In addition to the changes in payment policy described above, the current enrollment policy with its lack of coordination in enrollment periods may have contributed to low enrollment and risk selection. The Commission is recommending that a more structured enrollment process be established that provides for coordinated open enrollment periods and furnishes beneficiaries with objective, comparative information to allow them to make informed choices for HMO enrollment. Permitting beneficiaries to disenroll at the end of any month allows them to leave managed care plans more freely than is common in the private sector and may result in disenrollment when they require more services. This policy should be reevaluated, weighing benefits of reducing opportunities for risk selection by locking beneficiaries in over a longer period against the risk of beneficiaries being unable to "vote with their feet" in response to poor service and quality.

The Role of Cost Contracts. Cost contracts have long been made available for HMOs that do not want risk contracts. While this flexibility has ensured that a range of options is available to Medicare beneficiaries, it has also contributed to favorable selection for risk contracting HMOs with increased costs to Medicare. In markets where competitive pricing is implemented, cost contracts should not be available. If a choice of contracts is offered in other markets, HMOs should be required to commit to the contract form they choose for more than one year.

Future Work

In addition to these recommendations, the Commission will be in a position to offer this Committee and others in the Congress additional policy advice concerning Medicare managed care options over the next few months. Among the many projects on our work plan are:

- Setting capitation payments for the risk contracting program. These analyses will extend the Commission's previous work by identifying potential markets where competitive bidding would be feasible, designing a bidding process and the structure of premiums for high bidders, and considering how to establish payment rates in areas where competitive bidding is not applicable. The Commission will also update its assessment of risk adjustment methods. In addition, it will analyze regional variation in benefits offered to Medicare HMO enrollees resulting from the current structure of payment policy.

- Structuring choices for Medicare beneficiaries. Questions of interest include the range of arrangements that might be made available; whether there should be financial incentives for beneficiaries to choose more cost-effective options and how those incentives would be structured; identification of statutory barriers to managed care growth; and how to better manage the fee-for-service sector of Medicare including case management, bundled payments, and risk-based carveouts.

- Access to care for Medicare beneficiaries. Building on the Commission's previous work on access, a strategy will be developed for monitoring access for those enrolled in managed care plans. In addition, a survey will be fielded to explore beneficiaries' willingness to enroll in managed care and to learn what policy changes might facilitate enrollment.

- Graduate medical education. Medicare's current payment methodology for risk-contracting HMOs has a flaw that results in overpaying many HMOs for expenses related to graduate medical education. The Commission will assess the impact of this policy and the implications of moving towards alternative financing approaches.

Conclusions

This past year, the Commission focused on improving the methods of paying HMOs. Changing the payment method is long overdue, but is also only one element in a strategy to improve the performance of the Medicare program. Medicare is at a crossroads. It can remain the last open-ended program dominated by fee-for-service payment and unrestricted choice of providers or it can follow the rapid evolution of the market in the choices it offers and the incentives it creates for beneficiaries to choose more cost-effective options. In addition to the policy changes the Commission has recommended, the Medicare program needs to continue monitoring the development of the market over time. Markets will continue to change and Medicare needs to be able to adapt to both current and future trends.

Chairman THOMAS. Thank you very much, Dr. Wilensky.
Dr. Altman.

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Mr. ALTMAN. Thank you, Mr. Chairman. To keep things on a level playingfield and minimize time, I won't go through the recommendations that Gail Wilensky indicated, but I do want to make it clear that ProPAC shares the general thrust of those as well.

Another thing I want to make known to you is that the two Commissions are working together on managed care. We have had several meetings together. We are working collectively on our staffs to minimize duplication of effort, and in the future, we may be presenting you with joint recommendations and reports so as to be a more efficient help to you.

It is clear to us that Medicare needs to change. Managed care is growing quite rapidly in the Medicare Program, but it will never be able to get close to what is occurring in the private sector, and more importantly, you will never see the kinds of savings that you need in order to bring some balance in the trust fund and other areas unless and until substantial changes are made in Medicare, and particularly the way the current managed care system works. Gail has articulated well the problems with the AAPCC and some possible solutions which we mostly agree with.

What I would like to do this morning, though, is to give you the benefit of some recent research that ProPAC's staff have been engaged in to further your thinking about the issues; and quite frankly, Mr. Chairman, this information came as quite a shock to me, and I think I have a pretty good sense most the time of what is going on, and I suspect very few people realize what is going on.

One, we have been looking at total expenditures by the aged, not only the amount of money that is spent by Medicare and Medicaid, but also what is spent by the VA, the Defense Department, and other agencies of the government on behalf of the aged. And we have found that while, on average, it adds about 3.1 percent in total expenditures to the aged; in some areas of the country it exceeds 7 percent.

So to be fair in terms of an appropriate payment, it is appropriate to include these payments when one is calculating what the average aged person in an area receives, or you will discriminate against certain areas that currently use a lot of VA and DOD.

On the other side, the current AAPCC system was set up for the government to save a little, for the beneficiaries to get the benefit of joining these plans by getting extra benefits. What came as a rude shock to me is how large the difference is. Medicare has always prided itself on being the same program in all parts of the country and to all beneficiaries; that was its stock in trade. It turns out today that if you are a Medicare beneficiary in a high AAPCC area, a high-cost area, you can receive from the Medicare Program over $110 a month in extra benefits.

On the other hand, if you happen to be in a low AAPCC area, for a variety of reasons, you could receive zero extra benefits, even if you join a managed care plan. That is $110 versus zero per month. The average difference is $50.

Medicare is very quickly turning into a geographically experience-rated program, and it is being driven by what seemed like a fair way of paying, which is, you pay at the fee-for-service level, but it doesn't work like that.

The other thing we found is that the current way that Medicare pays the managed care plan for profits and administrative costs deals directly with the percent that they get for such services from the private sector. Then Medicare takes that rate and multiplies it times a much higher payment and gives the same percent, but a much higher amount to a plan.

Take two plans. One plan, say, provides most of its benefits to large beneficiary groups and therefore has low administrative cost; and let's say there is a fair amount of competition in that area, so their profit rates are down to a reasonable level.

Another area sells primarily in the fee-for-service market with a lot of extra advertising. So it has high administrative costs, plus maybe it doesn't have as much competition and so it has high profits. Medicare comes in and pays those rates. So you could have wide differences in the Medicare profits and administrative costs that are going to plans, when in fact the cost of providing those services to Medicare is exactly the same for both groups. So we are very concerned about restructuring the system to deal with that in a fair and equitable way.

Gail has indicated a number of changes that could be made in the way Medicare sets the rates, and they seem reasonable and consistent with the way we are thinking, as well; and the idea of phasing in and recognizing that you can't go to competitive bidding or some other form overnight also makes a lot of sense, but one needs to move.

We also recognize, when managed care started, the Medicare Program was very fearful of it, and there have been some abuses. We must recognize them, but also we recognize that most—the overwhelming proportion of Medicare beneficiaries in managed care plans enjoy it. They find the services more than adequate. They find the benefits fine. And this idea of counting on the 50–50 rule as the sole way to protect quality, that you have to have 50 percent of your population from the private sector, seems to be outdated. There are new and better methods of ensuring quality.

We need to guard the Medicare beneficiary against poor quality and bogus access, but the 50–50 rule is an arbitrary system that probably should go, if not immediately, over time, as we begin to develop better mechanisms for dealing with the system.

Now, one or two other points which we have talked about in context. The AAPCC includes a portion of the $10 billion of extra payments that Medicare makes to teaching hospitals, disproportionate-share hospitals and rural hospitals. We at ProPAC believe that the Congress was correct in trying to recognize certain special problems of the hospitals. We don't see the justification for continuing to include those payments in the AAPCC unless and until those moneys get redirected back to those institutions.

We don't want to force the managed care plans to use teaching hospitals if they don't want to. We want to encourage efficiencies. We believe other mechanisms should be set up to recognize the legitimate needs of this country for teaching hospitals, the special

problems of disproportionate-share hospitals and special problems of rural hospitals. So some mechanism needs to be developed to take that money out and then reallocate it in a different way.

Now, much has been made about the lack of adjustment for health status. There are 35 different adjusters and rate bases that Medicare now uses, but every study that has been done says, no matter how many different categories you come up with, we still do a poor job in adjusting for health status. And it is not because Medicare doesn't try; it turns out the methodology is just not there. And so the system gives many encouragements for plans, either directly or indirectly, to adjust who they select.

Now, to be fair to the managed care plans, most of them don't need to do anything. It is just how they market, who comes to them. My sense is that while there are a few bad apples out there that really do figure out ways, most of them don't have to do it. The problem you run into from the Medicare Program, though, is you are paying an average, and even if they didn't do anything, if they wind up with a less sick population, the Medicare Program loses substantial amounts of money.

So in total, Medicare should be moving much more to managed care. It is becoming the basic way health care is delivered in this country. Yes, senior citizens do need safeguards. One needs to be very concerned about the frail elderly, about people who have been in the fee-for-service for a long time. This should not be a shotgun, but we do need to move and move fairly aggressively to change the structure of the payment method and restructure the managed care program so that Medicare, as Gail has pointed out, moves into what is now becoming the dominant form of health care delivery in this country.

Thank you, Mr. Chairman.

[The prepared statement and attachments follow:]

TESTIMONY OF STUART H. ALTMAN, PH.D., CHAIRMAN PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Good Morning, Mr. Chairman. I am Stuart Altman, the Chairman of the Prospective Payment Assessment Commission (ProPAC). I am accompanied by Donald Young, M.D., Executive Director of ProPAC. I am pleased to be here today to discuss Medicare's managed care options and the improvements that are needed to improve their effectiveness. During my testimony, I will refer to several charts. These charts are appended to the end of my testimony.

You have recently held a series of hearings at which we and others have described the rapid rise in Medicare spending and the factors accounting for this growth. You also have examined the contributions of the Medicare program to the rising Federal deficit and the impending insolvency of the Medicare Part A Trust Fund. These are not new problems. In the early 1980s, Congress addressed these problems by enacting the Medicare prospective payment system for inpatient hospital services, physician payment reform, and other initiatives that collectively slowed the rise in Medicare spending and delayed the insolvency of the Trust Funds. As a result of these initiatives, the growth in Medicare expenditures per enrollee slowed considerably, falling substantially below the rise in private health insurance spending per member. These initiatives effectively controlled the increase in payment per unit of service, such as a hospital admission or visit to a doctor. They were less effective, however, in controlling the total number of services provided to each Medicare enrollee. More recently, Medicare spending has again accelerated, while the rise in private health insurance expenditures has moderated.

THE CONSEQUENCES OF FEE-FOR-SERVICE PAYMENT

Without additional reforms, Medicare spending is projected to continue growing about 10 percent a year. About half of this rise, or 5 percentage points, is due to increases in the number of Medicare enrollees and their average age and to inflation in the general economy. The remaining 5 percentage points is due to increases in the price of medical goods and services above general inflation and especially increases in the number and intensity of services furnished to Medicare enrollees. This rise in service volume and intensity is a result of several factors, including the aging of the

population and continuing medical advances. These factors are exacerbated, however, by Medicare's reliance on fee-for-service payment methods. These methods provide strong incentives for physicians and other providers to furnish more and more services and for beneficiaries to request more care, including the newest technologies. Frequently, however, the added services are of limited medical value.

THE TURN TO MANAGED CARE

The private insurance market has responded to rising health care costs by developing alternative payment systems based on capitation and managed care. These methods contain strong financial incentives for providers to control the number of services furnished, as well as the cost of each unit of service. There also are incentives for purchasers and their enrollees to choose the most efficient plans and to seek out plans that can demonstrate that they provide high quality care.

In 1993, 24 percent of insured individuals in the private sector were enrolled in health maintenance organizations (HMOs) (Chart 1). An additional 40 percent of individuals were enrolled in preferred provider organizations (PPOs), which use fee-for-service payment methods but limit enrollees choice of providers and frequently manage some of the care they receive. In contrast, in 1994 only 5.1 percent of Medicare beneficiaries were enrolled in the risk contracting program, which most closely resembles private sector options. This figure recently has increased to 6.6 percent. There are also substantial differences in Medicare risk plan enrollment across the states, ranging from more than 20 percent to none. While the number of Medicare beneficiaries choosing managed care plans is continuing to grow, we do not believe these rates will equal those for the privately insured under age 65 population until substantial changes are made in the Medicare program.

IMPROVING MEDICARE'S MANAGED CARE PROGRAMS

I would like to turn now, Mr. Chairman, to what we at ProPAC have learned about the operation of the current Medicare managed care options, their policies, and the problems with how they work.

Medicare offers several different types of managed care programs (Chart 2). In 1990, 1.9 million individuals were enrolled in one of these programs. By 1994, enrollment had increased to almost 3 million individuals (Chart 3), and by early 1995 more than 3.2 million beneficiaries were in Medicare managed care programs. More than 400,000 additional individuals were in the SELECT program. The most popular option is the fully capitated risk contracting program, which now enrolls over 76 percent of all Medicare managed care beneficiaries. Under a risk contract, Medicare pays a health plan a capitated rate per enrollee, and the plan is responsible for providing all necessary Part A and Part B covered services. Beneficiaries may be charged a copayment and, under certain circumstances, receive additional benefits. The plan can also offer Medicare enrollees additional benefits for which it can charge a premium, like other supplemental coverage policies. Plans must have annual enrollment periods and meet other requirements. Each month, however, beneficiaries may elect to disenroll from the plan.

In addition to the risk contracting program, Medicare also contracts with managed care plans to provide benefits on a cost-reimbursement basis. These contracts allow managed care plans to participate in Medicare without assuming financial risk for treating these patients. There are two types of cost contracts. The first, referred to as Section 1876 reasonable cost plans, provide all Part A and Part B Medicare benefits and must meet requirements that are similar to those for risk plans. In 1994, about 5 percent of Medicare's managed care beneficiaries were enrolled in one of the 27 cost plans (Chart 2). The second type of contract, known as health care

prepayment plans (HCCP), provides only Part B services. There were 62 of these plans in 1994, accounting for about 20 percent of Medicare's managed care enrollees.

Medicare also has several managed care demonstrations. These include the Medicare Select program, which uses a preferred provider network to furnish Medigap supplemental coverage. The Medicare program is also sponsoring the Social Health Maintenance Organization (SHMO) demonstration, which uses HMOs to link nursing home and community-based services with acute care. The PACE program provides managed care for the frail, generally poor, elderly population.

THE RISK CONTRACTING PROGRAM

The Medicare risk program has the potential to slow the rise in Medicare spending. The evidence to date, however, indicates that it has not achieved this goal. There are a number of reasons for this. They include the methodology used to calculate the payment for each plan, requirements regarding differences between each plan's payments and expected costs, and Medicare's policies regarding enrollment and disenrollment, including the lack of an adequate adjustor for health status. In addition, each year plans are allowed to convert from a risk contract to a cost contract or vice versa. There also are problems regarding Medicare's extra payments to teaching, disproportionate share, and rural hospitals that I will describe.

The development of Medicare's payment rate is based on a simple idea that has not worked as intended. The notion was to calculate a capitated amount that gives HMOs incentives to provide care at less cost than fee-for-service providers. In concept, Medicare was to generate savings because its payment to risk plans is set at a level less than the average spending that would otherwise be expected to occur in an area. Medicare pays a risk plan a capitated rate equal to 95 percent of the average Medicare fee-for-service program spending in the county in which the enrollee lives. This amount is adjusted to reflect age, sex, Medicaid status, institutional status,

and employer-based coverage. This average county-level spending is called the adjusted average per capita cost or AAPCC. In practice, this payment approach has numerous flaws that discourage many plans from participating and limit savings to the Medicare program.

CALCULATING THE AMOUNT OF THE AAPCC

A major problem with the AAPCC is the geographic area used to calculate the capitated payment rate. This area currently is the county. Many counties, however, may not have a sufficiently large population to adequately average fluctuations in fee-for-service payments. This may result in wide variations in the AAPCC from one year to another. Between 1994 and 1995, the increase in the AAPCC ranged from 2.1 percent to 9.5 percent for the 50 counties with the largest risk enrollment (Chart 4).

There also are large variations in payment rates among areas. In the top 50 counties, the monthly payment rates in 1995 varied from $292 in Marion County Oregon to $647 in Kings County New York. These regional variations are significantly larger than the variations in payment by the Federal Employees Health Benefit program for HMO coverage for federal workers. In addition, a plan offering services across several neighboring counties may receive very different capitated amounts even though their costs per beneficiary may be similar. For example, in 1995 in the Washington D.C. area the monthly capitated rate varied from $361 in Fairfax County to $543 in Prince Georges County. In the Minnesota Twin Cities Metro Area, the rate varied from $277 to $380 (Chart 5).

Part of the variation may be due to flaws in the calculation of the AAPCC, which excludes average expenditures for VA, military, or other programs used by Medicare enrollees. A recent ProPAC analysis found that the value of the services provided by these non-Medicare programs averaged about 3.1 percent of total Medicare per enrollee costs across all states. The variation across individual states ranged from 1.2

percent to 7.4 percent. The failure to recognize the value of the services furnished by VA and DOD facilities results in a capitated amount in some counties that is too low, possibly discouraging plan participation.

The variability and uncertainty regarding the level of the AAPCC may discourage some plans from participating in the program. Currently, about 25 percent of plans operating in the private sector participate in Medicare's risk contracting program. The wide variation in payment rates at the county-level also provides incentives and opportunities for plans to attract beneficiaries who live in counties with higher payment rates and to avoid those in counties with low rates.

While fee-for-service spending may provide a useful benchmark to gauge the level of the capitated payment, setting the rate at this level may not result in Medicare achieving the savings, especially in high cost areas, that HMOs should be able to achieve. In addition, this approach does not provide incentives for plans to compete with each other to enroll beneficiaries at the lowest price. It also encourages plans to participate in high cost areas, while discouraging participation in low cost areas.

COMPARING EXPECTED COSTS AND PAYMENTS

Medicare allows plans to choose to either return any difference between expected cost and Medicare payments to the program or to provide additional benefits, that otherwise would not be covered by Medicare, to the beneficiary. Not surprisingly, plans opt to provide the benefits rather than returning the savings.

These policies limit Medicare savings and result in beneficiaries' benefit packages varying by plan and where they reside. ProPAC has recently completed a preliminary analysis of the effects of these policies. Plans that wish to enter into or continue risk contracts are required to submit an adjusted community rate proposal (ACR) that calculates their expected cost (which include overhead and profits) to

provide Medicare covered services to Medicare enrollees. If these costs are less than the expected payment, plans are required to provide additional benefits to the enrollee or to return the difference to the Medicare program. Of course they all elect to provide the benefits, and the Medicare program fails to gain from their efficiencies. Plans argue that if they do not offer these extra benefits, given the structure of the Medicare program, few beneficiaries will join a managed care plan. While there may be truth in such contentions, it is hard to understand why all of the higher payments should go to these extra benefits.

Our analysis of the ACR data indicate that managed care plans in areas with high fee-for-service (FFS) costs have higher costs than plans in areas with lower costs. However, the costs incurred by managed care plans rise more slowly than FFS costs and Medicare payments. In fact, our analysis showed that in 1994 a $100 increase in Medicare's payment to the plan was associated with only a $72 increase in its cost of providing Medicare covered services. Consequently, in high cost areas plans returned $28 in additional services or reduced liability to the beneficiary for every $100 increase in the AAPCC, and Medicare did not share in the savings.

There is substantial variation in the monthly value of the added benefits that are provided at no cost to Medicare risk plan enrollees (Chart 6). Ten percent of enrollees received additional monthly benefits worth between $111 and $139. At the other end of the spectrum, 10 percent of enrollees received additional benefits of less than $10 with some receiving no extra benefits.

There is one other aspect of Medicare's treatment of expected plan cost and payments that I would like to mention, Mr. Chairman. As part of their calculations, plans include the combined percentage of their costs due to administrative overhead and profits in their private business. Medicare allows them to keep this same percentage of their expected costs for overhead and profit. Since Medicare's capitated payment is much higher than the capitated rate in their private business, the

actual payment per enrollee for administrative costs and profit is also much higher. This policy encourages plans with high administrative costs and profits to participate in the Medicare program, and it discourages plans that have kept these costs low.

TEACHING, DISPROPORTIONATE SHARE, AND RURAL HOSPITALS

There also are substantial problems with the way the Medicare risk contracting program deals with payments to teaching, disproportionate share, and vulnerable rural hospitals. Capitation and managed care in the public and private sectors is designed to increase the pressure on all providers to contain costs in order to compete. Certain providers, such as those located in remote rural areas or urban underserved areas may be disadvantaged in responding to such pressure. Other providers that furnish services such as training of the future health care work force and research and those that serve a disproportionate share of low income patients are also at risk. During 1994, 41 million people had no health insurance at some time during the year. Hospitals, physicians, and other providers traditionally have furnished needed services to many of the uninsured, by subsidizing these costs.

In 1994, the Medicare program provided about $10 billion in extra payments to certain rural, teaching, and disproportionate share hospitals to recognize the costs they incur that other hospitals do not bear. The extra costs to produce socially valuable services, however, may not be recognized in a price competitive health care financing and delivery system. The Medicare risk contracting program, in fact, does not appropriately account for these payments or costs. Because the AAPCC is based on Medicare's total fee-for-service payments in a particular geographic area, it includes the special payments to these facilities. The plan, however, is not obliged to use these providers or pass along the extra payments to them.

The Medicare program provides these extra payments in recognition of the unique contributions of these facilities by assisting them financially and, therefore,

maintaining access to care for Medicare beneficiaries. Removing these extra payments from the calculation of the AAPCC and distributing them to the appropriate providers, based on the care they furnish to Medicare risk enrollees, would allow these facilities to compete for patients on a more equal footing with other providers in their area.

LACK OF ADJUSTMENT FOR HEALTH STATUS

Another concern with Medicare's capitation rate is the lack of an effective means to adjust payments to reflect differences in beneficiary health status. Medicare uses five factors to adjust the capitated rate--age, sex, institutional status, Medicaid status, and employer-based coverage. However, these measures do not adequately account for variations in potential costliness, and plans have strong incentives to avoid sicker enrollees. The recent evaluation of the risk contracting program found that this lack of adequate risk adjustment was responsible for the failure of the risk contracting program to achieve the Medicare program savings that were expected. Program costs were almost 6 percent higher than they would have been under the fee-for-service option. A recent national household survey, however, did not find substantial differences in self-reported health status between those elderly enrolled in HMOs and those in the fee-for-service program.

Adjusting capitated payment rates to reflect health status will be much more difficult for the Medicare program than for the private sector because Medicare enrollees generally are sicker than the general population. It is even more important to do so, however, since it may be easier for plans to identify and avoid more costly Medicare beneficiaries.

ENROLLMENT AND DISENROLLMENT POLICIES

Medicare's enrollment and disenrollment policies differ substantially from those in the private sector. In the private sector, employees may not have the choice of a fee-

for-service indemnity plan. They also may be required to select from among a small number of the HMOs participating in their geographic area (Chart 7). Some employees pay higher premiums or face greater cost sharing requirements if they choose a more costly plan. Further, once they enroll in a plan, they must wait up to one year for the next open enrollment period before they can disenroll or change plans.

Unlike private sector enrollees, Medicare beneficiaries can choose any fee-for-service provider or participating managed care plan operating in their area. They may not bear the added costs related to choosing the most costly providers or plans. In fact, as I described, beneficiaries living in areas with the highest capitated payments receive substantial additional services at little or no added cost while beneficiaries living in lower cost areas must pay for their additional services. Further, Medicare beneficiaries enrolled in a capitated health plan may disenroll from that plan on a monthly basis and automatically be covered under Medicare's fee-for-service policies.

While Medicare's enrollment policies are more favorable to beneficiaries than private sector policies, it is important to note that the benefits they receive may not be as extensive as those provided to private sector HMO members. The lack of a prescription drug benefit is especially noteworthy.

There is much more movement of Medicare beneficiaries in and out of plans than there is in the private sector. Medicare enrollees in many areas seem to be confused about how the plans operate and, therefore, drop out. In other situations, Medicare beneficiaries seem to find it advantageous to disenroll from one HMO and enroll in another. In 1993, risk plan enrollment increased 37 percent; disenrollment during that year was 18 percent of enrolled beneficiaries (Chart 8).

The relationship between the rates of enrollment and disenrollment varied across geographic areas (Chart 9). The Dallas, San Francisco, and Philadelphia regions

were characterized by higher than average enrollment rates during 1993 and average or slightly higher disenrollment rates. Enrollment rates in the Seattle and Kansas City regions were notably low. The Boston and Denver regions experienced lower than average enrollment and disenrollment rates in 1993. Anecdotal information suggests that Boston enrollment has accelerated in the last year. No clear patterns emerge to explain the variations in these findings. The Seattle region had high private sector HMO penetration and exhibited little Medicare risk beneficiary turnover--either enrolling or disenrolling. In contrast, however, the San Francisco area, again with high private sector managed care enrollment, had higher than average enrollment rates, possibly due to the large number of plans, particularly new plans, in the area.

CHARACTERISTICS OF PLANS

Plan-specific data for those with the highest and lowest disenrollment rates highlights some characteristics that may be important in determining a plan's ability to satisfy Medicare beneficiaries (Chart 10). The five plans with the highest disenrollment rates in 1993 were for profit, independent practice association model HMOs. In contrast, the five plans with the lowest disenrollment rates were all nonprofit and group or staff model HMOs. Group and staff model HMO plans have more controls over enrollee service use and tend to have stronger relationships with their providers than IPAs. Further, they are the older HMO models, so they likely have a longer history in the private sector market. Plans with the lowest disenrollment rates also had participated in the Medicare risk program longer and, although they had about the same number of enrollees as plans with higher disenrollment rates, they had fewer new enrollees.

Analysis of data from the Group Health Association of America highlight some of these characteristics as important in distinguishing plans that participate under Medicare at all. IPA model HMOs and for-profit plans are the predominant types of HMOs, yet have lower than expected Medicare participation. Younger plans and

those with smaller total enrollments are also less likely to participate. These factors may reflect the added risk of the Medicare population, the administrative costs of enrolling Medicare beneficiaries, or the geographic distribution of plans.

In a survey conducted by the Office of the Inspector General, most Medicare risk plan enrollees indicated that they were satisfied with their care. In fact, most who disenrolled from a plan, enrolled in another risk plan. About one-third of those who left a plan did so for administrative reasons--they moved or their supplemental insurance changed. The rest disenrolled for reasons that may relate to the quality of the health plan or beneficiary preferences in health care delivery. These reasons for disenrollment included believing that premiums or copayments were too high, wanting to use providers not participating in the plan, or having to wait too long for appointments. It should be recognized, however, that most Medicare enrollees remain in the capitated plan they selected initially.

IMPROVING MEDICARE'S MANAGED CARE PROGRAMS

Major changes in Medicare's policies are necessary to achieve the savings that are possible through managed care. Information presented to the Commission suggests that managed care is capable of generating significant reductions in beneficiary utilization without impairing access to quality care. In addition, ProPAC analyses have shown that those states with the lowest hospital per capita cost increases between 1980 and 1993 generally had the highest percentage of private sector HMO enrollment in 1993. In contrast, all the states with the highest per capita cost growth had lower than average HMO enrollment (Chart 11).

Medicare, however, is not taking advantage of the potential for savings. To do so requires altering the method for determining the monthly capitated rate and the services included within this rate, changing the incentives for beneficiaries to choose this option, and encouraging HMO growth and participation in the program.

The first step is to change the way Medicare determines its capitated payment amount, especially breaking the link to fee-for-service spending at the county level. Medicare could avail itself of the competition that is occurring in the private market and require plans to compete for enrollees based on a premium bid from each plan for the standard set of Medicare benefits. Medicare could then set its capitated payment based on the average price submitted or some percentage of it. Medicare also should explore approaches that use a process of negotiation. Such an approach may be especially valuable in areas with a limited number of plans. Under any approach, however, Medicare can use its payments for comparable patients receiving care in the fee-for-service sector as a benchmark or ceiling in determining the capitated rate. This benchmark, however, should be adjusted to reflect the services Medicare beneficiaries receive from the Departments of Veterans Affairs and Defense that are not now included in the AAPCC.

The benchmark and the capitated rate also should not include Medicare's graduate medical education, indirect medical education, disproportionate share, or additional sole community hospital payments. Other mechanisms can be used to distribute these payment to the appropriate facilities when they provide services to Medicare beneficiaries enrolled in the managed care program.

To assist plans that wish to participate in the program and to reduce the cost of enrolling Medicare beneficiaries, Medicare should establish mechanisms to help reduce the cost of advertising. It may also need to require beneficiaries to pay more if they wish to stay in the fee-for service program. Such a requirement could be phased in over time.

In addition, the county should be eliminated as the geographic area used to determine the capitated amount. There are a number of alternatives that can be considered, including Medicare's current geographic groupings (metropolitan statistical areas) used for hospital payment. The feasibility of combining counties to achieve a

minimum population level or to reflect reasonable managed care market areas also should be explored.

The capitated rate that is set should cover Medicare's standard benefit package, although plans should be allowed to offer supplemental benefits to their enrollees for an additional premium. The current practice of comparing a plan's expected costs with its expected payments and allowing it to use the difference to provide additional benefits severely limits the opportunity for the Medicare program to share in the savings from more efficient service delivery. It also alters the uniform benefit structure of the Medicare program and raises questions of fairness for those beneficiaries who reside in relatively low cost areas.

Medicare's beneficiaries also should share in the savings when they choose a cost efficient plan. This can be done by linking their cost sharing requirements to the plans' premiums. Beneficiaries that wish to choose a more costly plan should share in the additional cost of their choice. Such an approach maintains Medicare's tradition of freedom of choice but provides financial incentives for beneficiaries to evaluate the value of a higher cost plan in terms of their added payment responsibilities. Plans, however, must make appropriate information concerning price, access, and quality of care available to Medicare enrollees during a coordinated annual open enrollment period.

Newly enrolled beneficiaries also should be given a limited period of time following each enrollment period during which they can switch plans or return to the fee-for-service sector. Thereafter, however, they should be required to wait for an annual enrollment season.

PROTECTING BENEFICIARY ACCESS TO QUALITY CARE

While expansion of Medicare's risk contracting program has the potential to slow the rise in Medicare spending, it also could have negative effects on beneficiary access to services and the quality of care they receive. Because plans use network providers, beneficiaries may be limited in their choice of physicians and hospitals. If their current provider is not in the plan's network, they will have to change practitioners, thereby disrupting their relationship with their physician and their continuity of care. In addition, managed care plans rely on utilization management practices that may limit the services they receive. Although there is no consensus about whether these restrictions impede or improve quality, they are sometimes perceived as limiting the beneficiary's access to services.

Collecting and making data available on plan and provider outcomes can help enrollees measure the strengths and weaknesses of different plans, and help them choose the plan that best meets their needs. The availability of such data in the Medicare managed care program varies widely. In California, Arizona, and Nevada, HCFA's regional office is disseminating information. In other areas, elderly advocacy and insurance advisory groups are compiling it. However, in most of the nation no such information exists.

Current program rules require participating HMOs to enroll at least 50 percent of their membership from sources other than Medicare or Medicaid. When this requirement was established, it was intended to be a quality assurance measure. The rule was predicated on the assumption that quality care for Medicare beneficiaries could be enhanced since plans would have to provide an appropriate level of care to attract private sector enrollees. Since then, quality measures have been developed in the private sector that allow enrollees to compare plan prices, outcomes, beneficiary satisfaction ratings, and other related information. These measures are now being refined to reflect the elderly population. Medicare should make these alternatives for

assuring quality of care widely available to its beneficiaries, rather than relying on arbitrary enrollment percentages.

Finally, Mr. Chairman, the Medicare program needs to move quickly to improve its ability to adjust payment rates to reflect differences in the health status of Medicare beneficiaries. Although coordinated annual enrollment and other plan requirements can help to reduce the ability of plans to favorably select the healthiest enrollees, this will continue to be a problem that will reduce the amount of Medicare savings from its managed care program.

CONCLUSION

Medicare's current managed care policies have several serious problems that have limited plan participation and beneficiary enrollment and kept the program from achieving the savings that are possible. These policies allow risk plans the opportunity to select healthier enrollees as well as individuals who reside in areas where Medicare's capitated payments are higher. They also allow beneficiaries the opportunity to return to the fee-for-service sector when they believe that is to their advantage. Further, beneficiaries who live in relatively high cost areas are rewarded for joining such plans with additional services that are not otherwise covered by Medicare. Beneficiaries residing in relatively low cost areas do not get these added benefits, and in fact may not even have the opportunity to join a risk plan since the low payment rate discourages plan participation.

The Commission would be pleased to continue working with you as you modify and improve Medicare's managed care policies. I would be happy to answer any questions you have.

Chart 1. Managed Care Enrollment, by State and Payer (In Percent)

State	Private Sector[a]	Medicare[b]	Medicaid[c]
National average	24.1%	5.1%	17.2%
California	51.4	20.9	15.3
Massachusetts	47.8	3.2	61.0
Oregon	40.4	19.9	70.2
Maryland	37.2	0.1	23.9
Rhode Island	36.6	7.8	1.2
Hawaii	33.8	8.9	4.8
Minnesota	31.8	9.1	27.7
Utah	31.8	0.0	42.7
New York	31.4	2.9	12.5
Colorado	30.6	9.5	8.4
Arizona	29.6	23.4	100.0
Connecticut	28.4	0.0	0.0
Wisconsin	28.3	0.0	24.2
New Mexico	25.8	11.6	0.0
Delaware	25.3	0.0	4.1
Michigan	23.6	0.5	20.0
Pennsylvania	22.9	1.7	24.9
Washington	22.5	9.2	55.8
Missouri	21.5	1.8	5.2
Illinois	21.2	3.8	6.9
New Jersey	21.0	0.1	5.0
Florida	20.0	13.1	19.9
Ohio	18.9	1.1	12.7
New Hampshire	17.8	0.0	12.3
Kentucky	17.8	0.5	0.0
Nevada	16.7	15.9	29.7
Vermont	15.6	0.0	0.0
Texas	15.0	2.6	1.5
Louisiana	13.9	0.0	0.0
Oklahoma	13.0	2.1	0.0
Virginia	11.0	0.1	0.0
Georgia	10.8	0.0	0.3
North Carolina	10.5	0.0	14.0
Indiana	9.7	0.3	0.0
Alabama	9.7	0.0	0.0
Kansas	8.5	0.6	0.0
Nebraska	8.5	1.3	0.0
West Virginia	7.4	0.0	0.0
Tennessee	7.2	0.0	100.0
Arkansas	7.0	0.0	0.0
Maine	6.2	0.0	0.0
South Carolina	5.6	0.0	0.0
Iowa	5.2	0.0	8.8
South Dakota	5.1	0.0	0.0
Montana	2.1	0.0	0.0
Idaho	2.0	0.0	0.0
North Dakota	0.6	0.0	0.0
Mississippi	0.1	0.0	0.0
Alaska	0.0	0.0	0.0
Wyoming	0.0	0.0	0.0

[a] Nonelderly privately insured population in health maintenance organizations, July 1993.

[b] Medicare population in risk contracting plans, January 1994.

[c] Medicaid population in fully or partially capitated plans, July 1994.

SOURCE: InterStudy; Employee Benefit Research Institute; Health Care Financing Administration, Office of Managed Care and Medicaid Bureau; and Lewin-VHI, Inc., *States as Payers: Managed Care for Medicaid Populations* (Washington, DC: National Institute for Health Care Management, 1995).

Chart 2. Summary of Medicare Managed Care Contracts, June 1994

Type of Contract	Number of Plan Contracts	Number of Beneficiaries Enrolled
Total	268	3,280,438
Risk	133	1,996,169
Cost	27	169,495
Health Care Prepayment Plan	62	655,559
Social HMO	4	22,052
SELECT	32	435,300
PACE	10	1,863

Chart 3. Medicare Managed Care Enrollment and Payments, 1990-1994

	Combined Contracts*				Risk Contracts			
	Enrollment		Payments		Enrollment		Payments	
Year	Number (In Millions)	Percent Change	Amount (In Billions)	Percent Change	Number (In Millions)	Percent Change	Amount (In Billions)	Percent Change
1990	1.9	—	$ 4.9	—	1.2	—	$4.2	—
1991	2.1	10.5%	5.9	18.7%	1.3	8.3%	4.9	16.7%
1992	2.3	9.5	6.9	17.7	1.5	15.4	5.7	16.3
1993	2.5	8.7	8.6	24.5	1.7	13.3	7.2	26.3
1994	2.9	16.0	10.6	23.1	2.1	23.5	9.1	26.4

Note: Data are as of September each year.

* The combined contracts include risk, social health maintenance organization, cost, and health care prepayment plans.

SOURCE: Health Care Financing Administration, Office of Managed Care.

Chart 4. Comparison of 1994 Versus 1995 Aged Monthly Adjusted Average Per Capita Costs, by County Risk Contracting Enrollment

Rank*	County	State	1995 Total Rate	Total Rate Change from 1994	Total Percentage Change from 1994
1	Los Angeles	California	$558.76	$26.73	5.02%
2	San Diego	California	458.81	23.84	5.48
3	Broward	Florida	544.02	26.81	5.18
4	Dade	Florida	615.57	40.05	6.96
5	Orange	California	523.12	24.11	4.83
6	Riverside	California	464.00	18.58	4.17
7	San Bernardino	California	466.92	21.75	4.89
8	Maricopa	Arizona	440.64	22.53	5.39
9	Cook	Illinois	485.26	24.09	5.22
10	Palm Beach	Florida	473.41	21.38	4.73
11	Multnomah	Oregon	373.35	15.78	4.41
12	King	Washington	377.09	13.23	3.64
13	Hennepin	Minnesota	362.85	10.75	3.05
14	Pinellas	Florida	410.08	26.17	6.82
15	Volusia	Florida	364.96	20.90	6.07
16	Bexar	Texas	404.37	22.51	5.89
17	Monroe	New York	400.40	23.97	6.37
18	Pima	Arizona	399.81	14.14	3.67
19	Hillsborough	Florida	414.04	20.73	5.27
20	Ramsey	Minnesota	379.82	21.34	5.95
21	Worcester	Massachusetts	453.09	15.27	3.49
22	Pasco	Florida	438.80	27.27	6.63
23	Kings	New York	646.88	36.33	5.95
24	Clark	Nevada	462.83	33.01	7.68
25	Orange	Florida	433.50	21.69	5.27
26	Washington	Oregon	374.82	21.16	5.98
27	Clackamas	Oregon	350.45	23.26	7.11
28	Bernalillo	New Mexico	352.38	9.77	2.85
29	San Mateo	California	397.73	18.03	4.75
30	Ventura	California	445.67	23.33	5.52
31	Denver	Colorado	435.63	23.63	5.74
32	San Francisco	California	467.03	20.90	4.68
33	Queens	New York	592.89	32.74	5.84
34	Cuyahoga	Ohio	474.45	9.66	2.08
35	Middlesex	Massachusetts	480.33	16.84	3.63
36	Snohomish	Washington	364.28	14.08	4.02
37	Honolulu	Hawaii	352.89	14.30	4.22
38	Kern	California	444.28	29.58	7.13
39	Nassau	New York	514.93	30.12	6.21
40	Jackson	Missouri	435.32	17.33	4.15
41	Jefferson	Colorado	371.29	19.51	5.55
42	Clark	Washington	324.53	22.14	7.32
43	Philadelphia	Pennsylvania	625.81	17.48	2.87
44	Montgomery	Pennsylvania	465.04	17.57	3.93
45	Suffolk	New York	477.83	21.56	4.73
46	Marion	Indiana	418.97	18.02	4.49
47	Nueces	Texas	415.09	21.42	5.44
48	Erie	New York	360.33	9.58	2.73
49	Marion	Oregon	291.50	20.08	7.40
50	Anoka	Minnesota	342.40	29.69	9.49

* The county with the largest number of Medicare beneficiaries enrolled in risk contracting plans is given the number 1 ranking.

SOURCE: Health Care Financing Administration, Office of Managed Care.

Chart 5. Standardized Per Capita Rates of Payment for Aged Enrollees in Selected Areas, 1995

Area	Rate of Payment
Washington, DC-Maryland-Virginia	
Washington, DC	540
Prince Georges County, MD	543
Montgomery County, MD	426
Manassas Park City, VA	464
Falls Church City, VA	408
Alexandria City, VA	407
Arlington County, VA	396
Fairfax City, VA	367
Fairfax County, VA	361
Twin Cities metro area	
Ramsey (St. Paul)	$380
Hennepin (Minneapolis)	363
Anoka	342
Dakota	334
Washington	324
Carver	285
Scott	277
Southern Florida	
Dade	616
Broward	544
Palm Beach	473
Southern California	
Los Angeles	559
Orange	523
San Diego	459

Note: The 1995 U.S. per capita cost for aged enrollees is $401; 95 percent of the U.S. per capita cost is $380, which corresponds to the standardized per capita rate of payment.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 6. Monthly Value of Medicare Non-Covered Benefits Provided at No Cost to Medicare Risk Plan Enrollees, By Decile of Risk Plan Enrollees, 1994

Enrollee Decile	Monthly Value of Benefits
1	$ 0 - 10
2	10 - 27
3	27 - 39
4	40 - 45
5	47 - 52
6	55 - 63
7	64 - 75
8	75 - 89
9	91 - 110
10	111 - 139

* Each decile includes 226,800 risk plan enrollees.

SOURCE: ProPAC analysis of Adjusted Community Rate Proposal data from the Health Care Financing Administration.

Chart 7. Firms Offering Various Insurance Options, by Size, 1994 (In Percent)

Firm Size	Indemnity	Preferred Provider Organization	Point of Service	Health Maintenance Organization
All firms	46%	30%	15%	22%
Employees				
10-499	46	30	15	22
500+	60	40	25	53

Note: More than 90 percent of the sampled firms had fewer than 500 employees. This proportion reflects national employment distributions.

SOURCE: A. Foster Higgins & Co., Inc., *National Survey of Employer-Sponsored Health Plans, 1994.*

Chart 8. National Enrollment and Disenrollment Rates for Medicare Risk HMOs, 1993

Year	Enrollment Rate (In Percent)	Disenrollment Rate (In Percent)	Enrollment Ratio
1989	34%	16%	2.1
1990	35	19	1.8
1991	30	18	1.7
1992	32	19	1.7
1993	37	18	2.1

Note: Plans in operation less than two years are excluded.

SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of Prepaid Health.

Chart 9. Enrollment and Disenrollment Rates for Medicare Risk HMOs, by Region, 1993

Region	Enrollment Rate (In Percent)	Disenrollment Rate (In Percent)	Enrollment Ratio
Nation	37%	18%	2.1
Dallas	52	24	2.2
Atlanta	31	23	1.3
San Francisco	47	18	2.7
Philadelphia	65	17	3.8
Seattle	18	16	1.1
New York	33	15	2.3
Chicago	20	14	1.5
Kansas City	17	13	1.3
Boston	22	10	2.1
Denver	26	9	3.0

Note: Plans in operation less than two years are excluded.

SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of Prepaid Health.

Chart 10. Characteristics of 10 Plans with Highest and Lowest Medicare Risk Disenrollment Rates, 1993

Disenrollment Rate	Average Disenrollment Rate	Average Enrollment Ratio	Average Years in Medicare	Average Medicare Enrollment	Model Status	Type
Highest	45.6%	1.8	5.3	14,999	For Profit	IPA
Lowest	6.3	2.2	7.2	15,242	Non Profit	Staff or Group

Note: Plans in operation less than two years are excluded.

SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of Prepaid Health.

Chart 11. Hospital Per Capita Cost Growth and Private Sector HMO Enrollment for Selected States (In Percent)

Rank	State	Hospital Per Capita Cost Growth 1980-1993[a]	1993 Private Sector HMO Enrollment[b]
1	Nevada	6.0%	16.7%
2	California	6.8	51.4
3	Kansas	7.4	8.5
4	Illinois	7.4	21.2
5	Arizona	7.4	29.6
6	Minnesota	7.5	31.8
7	Colorado	7.5	30.6
8	Maryland	7.7	37.2
9	Wisconsin	7.7	28.3
10	Rhode Island	7.8	36.6
National average	All	8.8	23.8
41	Georgia	9.7	10.8
42	South Dakota	9.9	5.1
43	New Jersey	9.9	21.0
44	North Carolina	10.0	10.5
45	Louisiana	10.0	13.9
46	Tennessee	10.1	7.2
47	Kentucky	10.3	17.8
48	Arkansas	10.3	7.0
49	South Carolina	10.5	5.6
50	New Hampshire	10.9	17.8

Note: HMO = health maintenance organization.

[a] Hospital per capita cost growth is measured as annual change in hospital costs per capita from 1980 to 1993.

[b] Private sector HMO enrollment is based on 1993 plan-level data as a proportion of each state's nonelderly privately insured population.

SOURCE: ProPAC analysis of data provided by InterStudy; Employee Benefit Research Institute; American Hospital Association; and Department of Commerce, Bureau of the Census.

Chairman THOMAS. Thank you very much, Dr. Altman.
Mr. Ratner.

STATEMENT OF JONATHAN RATNER, ASSOCIATE DIRECTOR, HEALTH FINANCING AND POLICY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. RATNER. Thank you, Mr. Chairman.

Mr. Chairman, Members of the Committee, good morning. We are pleased to be here to discuss opportunities to improve Medicare's method of paying HMOs that enroll Medicare beneficiaries.

As we stated this past February in testimony to this Committee, Medicare's dominant HMO option, known as the risk contract program, has not been able to harness the cost-saving potential of managed care. This finding takes on greater importance as health care payers, seeking to slow rapid growth in health spending, look increasingly to managed care, as we have heard.

About 7 percent of Medicare's population are HMO enrollees in the risk contract program. But recent proposals aimed at slowing Medicare spending growth call for moving a greater proportion of beneficiaries into HMOs. In view of congressional interest—and it is growing and expanding—in Medicare's HMO Program, you asked us to discuss the program's payment problems and its potential for change.

I am honored to follow Dr. Altman, Dr. Wilensky, but I confess it is a bit of a burden. I am going to be covering some of the same ground, but I will try to highlight a few things that are a little different.

In brief, HCFA needs to act promptly to correct flaws in the way Medicare sets HMO payment rates. We have heard already that enrollment growth has been very rapid. This increases the urgency of correcting rate-setting flaws that result in unnecessary Medicare spending.

As you stated at the outset, Mr. Chairman, enrollment, in fact, has been growing dramatically since 1992. In fact, in addition, enrollment growth is concentrated geographically. A rather remarkable statistic is that in 1994, 15 States, accounting for over half of Medicare beneficiaries, experienced double digit growth in HMO enrollment. Against this backdrop, let me just talk a bit about the payment problem.

How Medicare pays HMOs can be looked at from a couple of perspectives. From the perspective of Medicare and the taxpayer, there are a pair of problems. First, Medicare caps its potential savings from HMOs by setting its payment rate at 5 percent below fee-for-service costs. Now, the cost advantage of HMOs appears considerably greater than 5 percent, whether one looks at reports of specific HMOs generating great efficiencies, or HMO premiums for employees declining, or research studies.

There is HCFA-sponsored research, good research, that finds that Medicare HMOs, in caring for their enrollees, have costs at least 10 percent below fee-for-service. But as we have heard, Medicare's formula for setting these payment rates largely precludes the taxpayer and the Medicare Program from sharing in any of the HMO savings beyond 5 percent.

Now, second, by not adjusting its rates appropriately for whether HMO enrollees are healthier or sicker than average, Medicare pays more than necessary—by some estimates, about 6 percent too much; by others, about as much as 28 percent. This is the famous favorable selection or risk selection problem.

Now, these payment problems for Medicare coexist with real operational problems for HMOs in the Medicare business, and Dr. Wilensky has talked about some of those already. From the perspective of the HMOs, they see at least two problems. First, that the payment rates that Medicare has vary considerably between counties without necessarily reflecting the actual costs of providing care.

Here is an example: Medicare pays an HMO 27 percent less for serving a beneficiary living in Prince George's County, Maryland than for serving an otherwise identical person living in neighboring Montgomery County, Maryland, even if the two people are treated in the same facility by the same doctor.

Second, in some counties, the HMO rates can increase or decrease dramatically from year to year. This can deter HMOs from participating in counties with volatile Medicare rates.

Now, our work drives home two points that would make success more likely if the Congress pursues expanding Medicare managed care and better pricing of capitated health plans. One, with respect to pricing these plans in Medicare, one size does not—does not—fit all. Market conditions vary too much and in important ways, even among metropolitan areas. Two, details matter. How programs are designed and implemented often makes the difference between failure and success.

As for solutions, we believe a sensible approach would vigorously and concurrently pursue three strategies: Increase price competition among HMOs, make risk adjusters more accurate, and correct the pricing of HMO plans based on modifying the existing formula-based approach. Our written statement contains the details of these strategies.

By pursuing multiple strategies, by carefully monitoring experience, Medicare could benefit from early action, while gaining more information on how well these strategies work and how they might be better implemented.

In particular, we believe that HCFA should move quickly to implement a better risk adjuster. Last year, we recommended that they look at four risk adjusters and move quickly on demonstration projects. This year, we think they should select one of the four that is more administratively feasible and implement it as an interim fix. Meanwhile, HCFA could devote its resources to refining a more sophisticated risk adjuster.

Finally, we believe that HCFA should move forward without delay in launching demonstration projects on competitive bidding, and you have heard about that already. By trying competitive bidding in different regions, HCFA can obtain valuable information about what works and what doesn't work.

For example, demonstration projects could test different ways of penalizing HMOs that lose on the bidding. However, demonstration need not equate with delay. If a demonstration testing the competitive pricing of health plans results in savings, Medicare will reap

these gains without committing itself to a single nationwide solution immediately.

Mr. Chairman, that concludes my testimony. I will be glad to answer any questions you and the Committee Members may have.

[The prepared statement follows:]

STATEMENT OF JONATHAN RATNER, ASSOCIATE DIRECTOR HEALTH FINANCING AND POLICY ISSUES HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss opportunities to improve Medicare's method of paying health maintenance organizations (HMO) that enroll Medicare beneficiaries. As we stated this past February in testimony to this Committee, Medicare's current HMO option, known to providers as the risk contract program, has not harnessed the cost-saving potential of managed care.[1] In fact, Medicare has paid HMOs more for beneficiaries' treatment than it would have spent, on average, had those same beneficiaries received care in the fee-for-service sector.

A small portion--about 7 percent--of the Medicare population is enrolled in HMOs under the risk contract program. However, recent deficit reduction proposals aimed at slowing Medicare spending growth call for moving a greater portion of beneficiaries into HMOs. In view of increasing congressional interest in the Medicare HMO program, you asked us to discuss (1) recent trends in Medicare beneficiary enrollment in HMOs, (2) the obstacles preventing Medicare from realizing potential savings from HMOs, (3) the strategies that could enable Medicare to realize HMO savings, and (4) the Health Care Financing Administration's (HCFA) efforts to test HMO payment reforms. Our findings derive from examinations of Medicare program data, reviews of the literature, interviews with industry experts, discussions with HCFA officials, and our reports on this subject. (See the app. for a list of related GAO products.)

In brief, we found that recent enrollment growth in Medicare HMOs has been rapid, increasing the urgency of correcting rate-setting flaws that result in unnecessary Medicare spending. By not tailoring its HMO capitation payment to how healthy or sick HMO enrollees are, HCFA cannot realize the savings that private-sector payers are able to capture from HMOs. In addition, we derive two lessons from our review of ways to fix Medicare's HMO capitation payment:

-- First, with respect to rate-setting, one size does not fit all, so a multipronged approach makes sense. The large disparities in market conditions between states--from California to Maine--call for solutions keyed to market conditions. Several broad strategies--increasing price competition among HMOs, using better risk adjustors, and revising Medicare's capitation rate--show promise for enabling Medicare to realize these savings.

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[1]Medicare: Opportunities Are Available to Apply Managed Care Strategies (GAO/HEHS-95-81, Feb. 10, 1995).

-- Second, with respect to achieving the promise of such initiatives, details matter. How these strategies would be designed and implemented could mean the difference between success and failure.

Although HCFA is planning demonstration projects to study ways to correct its HMO rate-setting method, results are likely to be years away. We believe that, in the short term, HCFA can mitigate its capitation rate problem by introducing a better health status risk adjuster. HCFA also should proceed promptly to test competitive bidding and other promising approaches to setting HMO rates that reduce Medicare costs. Given the recent acceleration in Medicare's HMO enrollment growth, we believe that correcting Medicare's HMO payment rate problems should become a HCFA priority.

BACKGROUND

In 1982, the Congress created the Medicare risk contract program to capitalize on the potential cost savings associated with HMOs. Under this program, HMOs are paid a flat fee for each Medicare beneficiary enrolled. The law sets HMO payments for comprehensive care at 95 percent of the estimated average cost to Medicare of treating the patient in the fee-for-service sector. HCFA, which oversees the Medicare program, calculates these payment rates using a three-step process. HCFA determines:

-- The base rate. HCFA calculates the projected Medicare expenses nationwide for the average beneficiary in the next year.

-- The adjusted average per capita cost (AAPCC). HCFA adjusts the base rate for differences in medical costs among the counties and multiplies the result by 0.95.

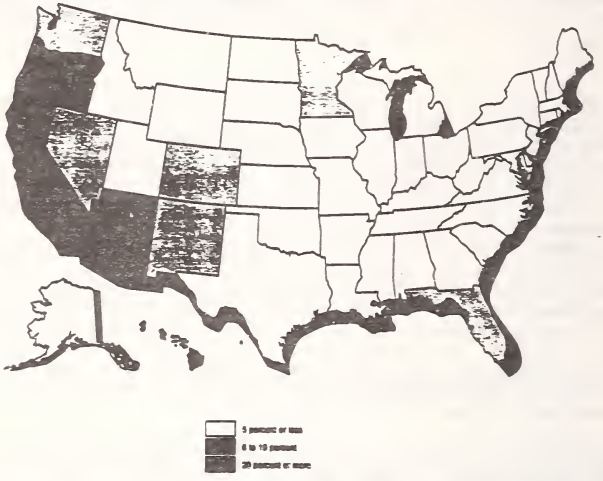
-- The capitation rate after adjusting for health status risk. HCFA adjusts the AAPCC for enrollees' demographic characteristics--age, sex, Medicaid eligibility, residence in an institution such as a nursing home. This "risk adjustment" attempts to prevent HMOs from benefiting from favorable selection of health risks, which occurs when HMOs enroll beneficiaries that are healthier--and therefore less costly to care for--than those in the fee-for-service sector.

Although in existence for over a decade, the risk contract option remains a relatively small part of the Medicare program. As of May 1995, about 7 percent of Medicare beneficiaries were enrolled in plans offered by the 164 HMOs currently participating in the program.

BENEFICIARY ENROLLMENT GROWING IN MEDICARE'S RISK CONTRACT PROGRAM

The Medicare risk contract program may be poised for substantial growth in enrollment during the next few years. HCFA reports that three-fourths of all Medicare beneficiaries now live in areas where they could enroll in a risk contract HMO. Although beneficiary enrollment in these HMOs is relatively low, in recent years the program has grown dramatically in both beneficiary enrollment and HMO participation.

Figure 1: Percent of Beneficiaries Enrolled in HMOs With Risk Contracts, By State, 1994



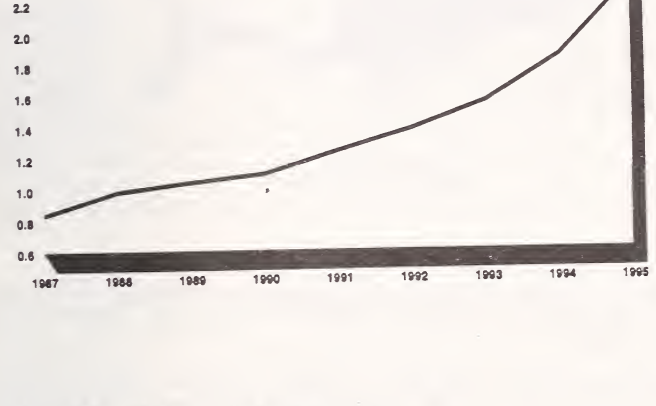
Source: HCFA, Bureau of Data Management and Strategy. Enrollment information based on computer runs using the Denominator File.

As of May 1995, about 2.6 million beneficiaries were enrolled in the risk contract program--about 7 percent of the total Medicare population.[2] Although this share is small,

[2]Another 2 percent of Medicare beneficiaries belong to HMOs that either have cost contracts or are Health Care Prepayment Plans. These programs reimburse HMOs on a cost basis and lack the financial incentives of risk contracts to reduce costs. Consequently, these cost contract HMOs are not relevant to proposals that would expand Medicare's use of capitated health plans.

recent HMO enrollment of Medicare beneficiaries has grown rapidly. From 1990 through 1992, enrollment grew by about 13 percent annually but then, during 1993 and 1994, grew by an annual average of 23 percent. Preliminary data for 1995 suggest a growth rate approaching 30 percent. Similarly, the number of risk contract HMOs, which declined substantially during the early years of the program, since 1991 has nearly doubled from 83 to the current 164.

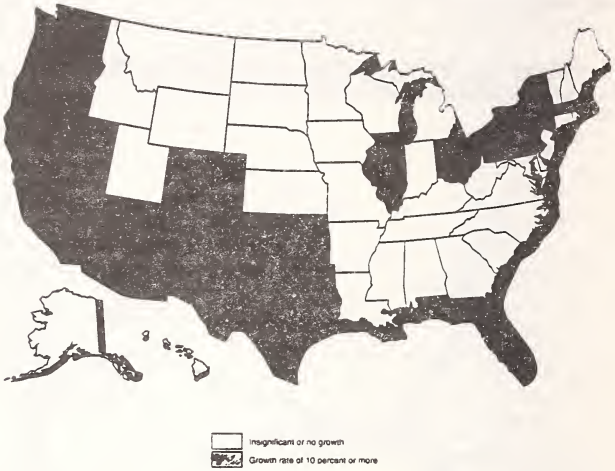
Figure 2: Number of Beneficiaries Enrolled in HMOs With Risk Contracts (in millions), 1987-1995



Source: HCFA, Office of Managed Care

In 1994, HMO enrollment in California and 14 other states--which account for 55 percent of all Medicare beneficiaries--experienced double-digit growth. The other states showed no enrollment growth. For the most part, these are states where HMO market penetration has been extremely low.

Figure 3: Fifteen States Had Double-Digit Growth in HMO Enrollment in 1994



Source: HCFA, Bureau of Data Management and Strategy. Enrollment information based on computer runs using the Denominator File.

Note: States that had 1 percent or fewer Medicare beneficiaries enrolled in risk contract HMOs were classified as "insignificant or no growth" states. Hawaii, with a growth rate of 6 percent in 1994 was also classified in that group. Ohio, with a growth rate of 9.1 percent, was classified as a double-digit growth state.

HMO RATE-SETTING METHODOLOGY THWARTS MEDICARE'S EFFORTS TO REALIZE SAVINGS

Our work suggests that Medicare's HMO rate-setting methodology does not maximize the potential of managed care to yield cost savings and, in some cases, can even discourage HMO participation in the program. By tying HMO payments to Medicare costs in the fee-for-service sector, the current methodology causes three problems. First, the rate-setting formula restricts potential savings and ignores the ability of competitive market forces to help produce additional savings. Second, the lack of adequate risk adjustors in the formula allows some HMOs to be overcompensated, given the health status of their enrollees. Third, the formula may discourage plan participation by setting payments that are too low in some areas and by causing rates to vary greatly both across geographic areas and over time.

Formula Encourages Competition Between HMOs That Primarily Benefits Enrollees

Under the present system, all HMOs in an area are paid the same capitation rate. With the payment rate fixed and independent of both HMO costs and the competitiveness of the local managed care environment, HMOs compete only for the enrollment of Medicare beneficiaries. Efficient, low-cost HMOs may be able to offer more generous benefit packages to enrollees and still prosper under the fixed capitation rate. However, because the payment rate is fixed, the government derives little benefit from either increased competition between HMOs or increased efficiency of HMOs. Moreover, Medicare beneficiaries have only limited incentives to seek care from low-cost health plans.

Medicare may be underestimating the efficiency of HMOs, and requiring an HMO "discount" from fee-for-service costs that is too modest. The HMO capitation rate is set by statute at 95 percent of the AAPCC, in other words, 5 percent below the estimated cost of serving beneficiaries in the fee-for-service sector. HMOs that can attract Medicare enrollees and provide health care for less than the capitation rate--for example, for 85 percent of fee-for-service costs--keep the difference (within limits) between their costs and the capitation payment.[3]

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[3]HMOs are permitted to earn profits up to the level earned on their non-Medicare business--the adjusted community rate (ACR). Profits earned in excess of the ACR must either be returned to HCFA or used to provide beneficiaries with additional benefits or reduced copayments and deductibles.

The recent surge in HMO participation indicates that many organizations now view Medicare risk contracts as potentially lucrative. In addition, in caring for Medicare beneficiaries, HMOs are estimated to achieve cost savings in excess of 5 percent. Research suggests that HMO costs in caring for their enrollees are at least 10 percent less than HCFA would have spent on fee-for-service care for them.[4] Finally, some experience of private-sector employers with HMOs suggests that the 5-percent discount may be too low, especially in certain urban areas with mature managed care markets. In those markets, even a larger discount (lower capitation rate) might not significantly discourage HMOs' participation in Medicare risk contracts.

Risk Adjustment Methodology Inadequate to Prevent Overcompensation

Currently, HCFA's capitation payment to HMOs is "risk adjusted" only for four demographic factors: beneficiary age, sex, Medicaid status, and institutional status. These adjustments are designed to modify HMO payments for expected variations in medical costs. For example, the capitation payment is higher for older beneficiaries, since they are expected to require more medical care than younger beneficiaries. However, this risk adjustment is inadequate because it does not specifically adjust for the health status of enrollees. By enrolling the healthier individuals, HMOs need deliver less health care but are compensated as if they enrolled a costlier clientele--both the healthier and the sicker individuals.[5]

Our review of studies on risk selection shows that, because most HMOs benefit from favorable selection (the healthier individuals typically enroll in HMOs), Medicare has paid HMOs more than it would have paid for the same patients' care by fee-for-service providers.[6] Estimates of the excess payments range from almost 6 percent to 28 percent. Although these estimates are based on 1991 data, our review suggests that favorable selection

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[4]Randall S. Brown and others, "Do Health Maintenance Organizations Work for Medicare?" Health Care Financing Review, Fall 1993, Volume 15, Number 1, p. 14.

[5]HCFA uses administrative means, such as prohibiting HMOs from refusing to enroll beneficiaries with pre-existing conditions and monitoring HMO marketing materials, to lessen the ability of HMOs to purposely attract healthier-than-average beneficiaries.

[6]Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs. GAO/HEHS-94-119, pp. 21-23.

persists despite HMO enrollment expansion. HCFA officials agree that the risk contract program displays favorable selection, though they believe that excess payments are at the lower end of this range.

Formula Produces Capitation Rates That Vary Considerably Within Market Areas And Over Time

Capitation rates are set separately for each U.S. county and vary considerably nationwide among regions and states, among urban and rural counties, and even among neighboring counties. This variation may discourage some HMOs from participating in risk contracts. For example, under the present system, an HMO is paid 27 percent less for serving a beneficiary living in Prince George's County, Maryland, than for serving an otherwise identical beneficiary living in neighboring Montgomery County, Maryland--even if the two individuals are treated in the same facility by the same doctor.[7] The inconsistency of payment rates across county lines leads some HMOs to enroll beneficiaries from a limited portion of the HMO's service area.

The geographic problems in the capitation rates are caused by the formula's tie to local fee-for-service spending, which reflects local variations both in the prices and volume of medical services used by Medicare beneficiaries. Much of this variation may, however, be attributable to underutilization of health care in some areas and overutilization in others instead of differences in the cost of providing appropriate health care. If fee-for-service beneficiaries use a large number of services (either because beneficiaries demand these services or because their doctors order additional services), then HMO payment rates will be relatively high in that county. In contrast, if Medicare fee-for-service beneficiaries use few services--perhaps because of inadequate transportation or a lack of providers in rural areas--then HMO payment rates will be relatively low. As a result, rates in some areas are too low to induce HMO participation in the risk contract program, while in other areas rates are too high for Medicare to realize the potential cost savings generated by capitated payments.

HMOs also can be discouraged from participating in risk contracts because payment rates can increase or decrease dramatically from year to year. This problem is most prevalent in rural counties. Because of the small number of Medicare beneficiaries in such counties, a few very expensive illnesses can drive up the following year's capitation rate, while an especially "healthy" year will have the opposite effect. HMO

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[7]Capitation payments are based upon where the beneficiary lives, not where he or she receives medical care.

officials complain that rate instability hurts their ability to conduct long-term planning--for example, by complicating decisions about investing in new clinics and expanding physician networks--and can cause wide swings in enrollees' premiums from year to year.

STRATEGIES EXIST FOR MEDICARE TO REALIZE SAVINGS

By modifying the present payment system, HCFA could help generate savings for Medicare. Our review of the experience of the private sector, reforms in other public health care programs, and empirical research suggests that a number of strategies hold promise. These strategies can be grouped into three broad categories: increasing price competition among HMOs, developing better risk adjustors, and revising the AAPCC-based capitation rate.

In our view, potential Medicare savings will be greatest if strategies in all three categories are concurrently pursued. An attempt to address all obstacles in a uniform way across all regions of the country is unlikely to be successful. This is because the predominant challenges to saving costs in large cities are not necessarily the same ones that exist in rural counties and because the challenges vary from region to region, even for otherwise similar communities. Consequently, a variety of reforms is warranted; local conditions would determine the particular mix of solutions for any specific area.

The details of how any reform is implemented matter. Changing the Medicare policies for paying HMOs could affect their decision to participate in risk contracts and the benefits they provide. This, in turn, may affect Medicare beneficiaries' decisions to enroll in managed care plans and the quality of care they receive in those plans. Thus, estimating the potential dollar savings and determining the best method of implementing specific reforms may be possible only after quickly conducting and evaluating demonstrations.

Increasing Price Competition Among HMOs

Price competition that would enlist market forces to help contain Medicare costs could be encouraged by requiring qualified HMOs to submit competitive bids. The accepted bid would set the capitated rate at which HMOs would provide comprehensive care to Medicare enrollees in an area. This approach completely decouples capitation rates from average fee-for-service spending. Under a competitive bidding system, HMOs would have an incentive to submit bids that reflect their actual costs of providing

health care to Medicare enrollees. Low bidders would be rewarded with risk contracts. High bidders could be excluded, included if they accepted the winning bid amount, or included but subject to a financial penalty.

A competitive bidding strategy may be most effective in urban areas with well-developed managed care markets. The details for implementing such a strategy would determine the strength of incentives driving HMOs to submit low bids and the amount of choice available to beneficiaries. For example, excluding high bidders from participating in risk contracts would maximize HMOs' incentives to submit low bids, but reduce the choice of plans available to beneficiaries. Allowing high bidders to participate but with a penalty--perhaps having to charge the difference between their bid and the accepted bid as a premium to seniors--would create a weaker incentive for low bids but would allow beneficiaries a wider choice of plans.

Competitive bidding, rate negotiation, and beneficiary incentive approaches have been used successfully in other public health insurance programs. Arizona, for example, since 1982 has delivered health care to its indigent population mostly through capitated managed care organizations where the capitation rates are set through a competitive bidding process. A recent study concluded that, compared to traditional Medicaid programs (predominately fee-for-service), Arizona achieved significant cost savings and a lower rate of expenditure growth.[8] The California Public Employees Retirement System (CalPERS), serving about 1 million members, also relies upon price competition among health plans and consumer incentives to control costs. Negotiating rates with HMOs has helped CalPERS to achieve reductions in premiums in each of the past 3 years, ranging from 0.4 percent in 1993-4 to 5.2 percent in 1995-96.[9]

Designing a good competitive bidding system requires attention to many issues, such as whether beneficiaries in plans that lose the bidding must shift to the winning plan. In addition, savings may not be realized immediately because of high initial start-up costs--for example, developing the bidding process and establishing the necessary management information systems. Administrative expenses may be high as well.

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[8]Managed Medicaid Cost Savings: The Arizona Experience, Laguna Research Associates (San Francisco: 1994).

[9]Health Insurance: California Public Employee's Alliance Has Reduced Recent Premium Growth (GAO/HRD-94-40, November 1993). Jackson Hole Group, Responsible Choices for Achieving Reform of the American Health System, eds. Paul Ellwood and Alain Enthoven, (March 1995).

Arizona's experience illustrates these points. Arizona spends on Medicaid administration an amount equal to over 11 percent of its program's acute care medical costs. This is about twice as much as comparable states spend administering their traditional fee-for-service Medicaid programs. This suggests that the effective use of managed care may require strong administrative structures that can provide adequate oversight and manage program resources efficiently.[10] Even so, Arizona's experiment with competitive bidding seems to have paid off, providing health care to beneficiaries while saving the state money.

Market forces could be introduced in other ways besides requiring competitive bidding. These include approaches that would encourage Medicare enrollees to be more price sensitive--they range from requiring newly eligible Medicare beneficiaries who choose fee-for-service to pay slightly more than those beneficiaries who choose a managed care plan, to approaches that would allow beneficiaries to "price shop" among a list of approved HMOs and share a portion of any cost savings with the government. Because they are so far untried, the extent to which these schemes would increase beneficiaries' price sensitivity and help control Medicare costs is unknown. As with competitive bidding, there is a wide variety of ways in which these Medicare reforms could be implemented. However, a fuller discussion is outside of the scope of this statement.[11]

Improving Risk Adjustors

In earlier reports, we noted that researchers have proposed several alternative risk adjustment methods to reduce HMOs' incentives to enroll only relatively healthy Medicare beneficiaries. Each of these alternative methods attempts to measure the health status of enrollees more fully than HCFA's method. These proposals can be judged according to a number of

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[10]Our work on the Medicare risk contract program emphasizes the importance of effective mechanisms, whether administrative or market based, to ensure quality, resolve beneficiaries' complaints, and deter and pursue fraud and abuse.

[11]For example, under several proposals, beneficiaries could be given a voucher that would allow them to choose between traditional Medicare or among several qualified HMOs. HMOs would compete for enrollees on both price and benefits offered (subject to a minimum benefits requirement). Beneficiaries who choose a less expensive health plan would be allowed to keep a part of the difference between the premium cost and voucher amount; the rest would return to the federal treasury. However, neither vouchers, nor other proposals with similar consumer incentives, have been tried in Medicare.

generally accepted operational criteria. For example, a good risk adjustor would be inexpensive to administer, reduce favorable selection, create incentives for HMOs to provide appropriate care, and would not be subject to manipulation by participating HMOs. However, no risk adjustor is likely to exhibit all these positive traits because these criteria have tradeoffs. For example, a more complex risk adjustor may be more successful in reducing favorable selection but may do so only at a high administrative cost.

Recently, we evaluated 10 possible risk adjustors.[12] None emerged as the definitive solution to the problem of the current system. However, 4 of the 10 adjustors we examined were potentially superior to the current system and seemed to entail less administrative burden than the most sophisticated risk adjustors. One of these adjustors--clinical indicators--would adjust capitation rates for the presence or absence of a particular chronic health condition (such as heart disease, stroke, or cancer). Two other promising clinically-based risk adjustors include information not only on whether a beneficiary has a specific condition but also on the severity of the illness.[13] In the fourth approach, HMO capitation payments would be linked to beneficiaries' own views of their physical and emotional health.

Improving the AAPCC Capitation Rate

HCFA could require steeper discounts from HMOs than the present 5-percent discount off the estimated local fee-for-service cost. Although this would lower payments to HMOs, it may not necessarily have a large impact on their participation in Medicare risk contracts. Previous research indicates that enrollment of healthier-than-average beneficiaries, combined with an imperfect system of risk adjustment, results in excessive payments to HMOs--even after factoring in the 5-percent discount. The number of HMOs seeking risk contracts has increased from 109 to 164 in less than a year and a half. Thus, HMOs may continue to find Medicare risk contracts attractive--even at a somewhat larger discount. However, if health plans react by offering less generous benefit packages, fewer seniors may be attracted to managed care.

The method used for calculating the AAPCC could also be improved by assigning a greater weight to the influence of local medical prices and a lesser weight to the influence of local

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[12]Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs (GAO/HEHS-94-119, Sept. 2, 1994).

[13]The two risk adjustment measures are Ambulatory Care Groups (ACGs) and Diagnostic Cost Groups (DCGs).

service utilization patterns in the fee-for-service sector. Modifications could also be made so that the AAPCC reflected HMO market areas, rather than artificial political boundaries. For example, defining a single capitation rate for a metropolitan area would eliminate the possibility that an HMO would receive more for serving a senior in one county than it would for serving an otherwise identical senior living in an adjacent county. These changes would also tend to reduce the volatility of the AAPCC over time and consequently increase HMO participation in the risk contract program.[14]

HCFA PLANS TESTS OF HMO PAYMENT REFORMS

HCFA is planning to conduct demonstration projects that will examine several proposals for modifying or replacing the current method of determining payment rates to HMOs. Some results of these demonstrations could emerge during fiscal year 1996, but we believe that a thorough assessment of the demonstrations is, at best, several years away. The proposals are at various stages, from solicitation of proposals from private contractors to implementation of the demonstration itself.

Specific projects that HCFA is pursuing include: (1) a study of "outlier pools" as a way of adjusting for health risk retrospectively; (2) a demonstration of competitive bidding as a means of setting the capitation rate; (3) a demonstration of a sophisticated health status risk adjustor; and (4) an open-ended demonstration project that would study one or more proposals for improving Medicare managed care.

In our view, these demonstration projects are steps in the right direction, though somewhat overdue. In light of Medicare's current losses due to the risk contract program--estimated at between 0.5 billion and 2.5 billion per year--there may be other steps that HCFA could take immediately to stem losses. For example, HCFA could increase the HMO "discount" from its current 5 percent in selected areas. These might be areas where Medicare HMO enrollment is growing rapidly or where most HMOs do not currently charge beneficiaries a premium.

CONCLUDING OBSERVATIONS

Several factors are at work that change the context of Medicare managed care:

-- the recent and anticipated growth in risk contract enrollments,

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[14]Annual Report to Congress 1995, Physician Payment Review Commission (Washington, DC: 1995).

-- broad congressional interest in expanding Medicare's use of managed care, and

-- HCFA's recent steps toward undertaking demonstration projects on expanded managed care options and improved Medicare HMO pricing.

These factors lend a new momentum to efforts that would fix Medicare's method of paying HMOs, to stem Medicare's losses under the risk contract program, and then turn them into savings.

Our work drives home two points that would make success more likely if the Congress pursues expansion of Medicare managed care and better pricing of capitated health plans: First, one size does not fit all--at least with respect to pricing capitated health plans in Medicare. Market conditions vary too much and in important ways, even among metropolitan areas. Second, details matter. How programs are designed and implemented often means the difference between success and failure.

As a result, we believe a sensible approach would concurrently pursue the three major strategies--increasing price competition among HMOs, making risk adjustors more accurate, and correcting the pricing of HMO plans by modifying the existing AAPCC approach. Moreover, by adopting a "try and track" stance, Medicare could benefit from early action while gaining more information on how well these strategies work and how they might be better implemented.

In particular, we believe that HCFA should move quickly to implement a better risk adjustor. Last year, we recommended that HCFA promptly undertake demonstration projects on four risk adjustors that we have identified as promising in accuracy and administrative feasibility. Today the increased urgency of fixing the HMO capitation rate may argue for an alternative approach: HCFA could select one of these risk adjustors to implement as a near-term fix. Meanwhile, HCFA could devote its resources to refining and implementing a more sophisticated risk adjustor. As another interim measure, HCFA could also increase, in selected areas, the HMO 5-percent discount.

Finally, we believe that HCFA should move forward without delay in implementing demonstration projects on competitive bidding. By trying competitive bidding in different regions, HCFA can obtain valuable information about how the structure of the bidding process affects outcomes--such as the tradeoff between maximizing HMOs' incentives to submit low bids and ensuring the widest possible choice of plans for beneficiaries. Moreover, Medicare can likely reap some of the potential gains from competitive pricing of health plans.

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Mr. Chairman, this concludes my testimony. I would be glad to answer any questions you and the committee members may have.

APPENDIX I

APPENDIX I

RELATED GAO PRODUCTS

Medicare: Opportunities Are Available To Apply Managed Care Strategies (GAO/T-HEHS-95-81, Feb. 10, 1995).

Health Care Reform: Considerations for Risk Adjustment Under Community Rating (GAO/HEHS-94-173, Sept. 22, 1994).

Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs (GAO/HEHS-94-119, Sept. 2, 1994).

Managed Health Care: Effect on Employers' Costs Difficult to Measure (GAO/HRD-94-3, Oct. 19, 1993).

Medicare: HCFA Needs to Take Stronger Actions Against HMOS Violating Federal Standards (GAO/HRD-92-11, Nov. 12, 1991).

Medicare: PRO Review Does Not Assure Quality of Care Provided by Risk HMOs (GAO/HRD-91-48, March 13, 1991).

Medicare: Increase in HMO Reimbursement Would Eliminate Potential Savings (GAO/HRD-90-38, Nov. 1, 1989).

Medicare: Reasonableness of Health Maintenance Organization Payments Not Assured (GAO/HRD-89-41, Mar. 7, 1989).

Medicare: Health Maintenance Organization Rate Setting Issues (GAO/HRD-89-46, Jan. 31, 1989).

Medicare: Physician Incentive Payments by Prepaid Health Plans Could Lower Quality of Care (GAO/HRD-89-29, Dec. 12, 1988).

Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 17, 1988).

Medicare: Uncertainties Surround Proposal to Expand Prepaid Health Contracting (GAO/HRD-88-14, Nov. 2, 1987).

Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations (GAO/HRD-86-97, July 16, 1986).

Problems in Administering Medicare's Health Maintenance Organization Demonstration Projects in Florida (GAO/HRD-85-48, March 8, 1985).

Chairman THOMAS. Thank you, Mr. Ratner.

A portion of your testimony stimulated a question back here.

The gentlewoman from Connecticut.

Mrs. JOHNSON. I thank the panel for their excellent testimony, and as one who is particularly interested in the reimbursement of medical education, I look forward to more specific conversations with you about how we can assure that not only do we carry forward into the future the tradition of outstanding medical education that has marked American medicine, but that we do it in a way that hopefully all beneficiaries—that is, all of us—participate in, rather than just Medicare participants.

But I don't want to go to that issue right now. I want to ask a general question of the panel. I hear what you are saying about the AAPCC. I hear what you are saying about how we reimburse risk contracts, 50–50 rules for HMOs. What you are talking about is changing the current system to fix it for the future.

If we set the payment rates relative to the current Medicare payments, we are going to carry into the future the problems of that structure, which are numerous as you have just elucidated. Why can't we go around that system and base the new Medicare premium on the average premium of plans in that market that provide the Medicare basket of services? In other words, why don't we go to the market and see what they are charging for those services?

Now, I understand the problem of risk, but my impression from talking with plan operators is that if they are able to market aggressively, they are able to reach a certain critical mass of senior involvement with an established managed care plan, they don't care about risk. And I have had companies who have done this, sit across the table from me and say, here are the three ways we can medically underwrite X, Y and Z; this is how they work, and we don't use them once we get a critical mass of size.

When you look at how some seniors are being overmedicated, when you look at the costs of hospice care versus nonhospice care, when you look at the ability of managed care plans to deal with frailty, to deal with prevention, there are just extraordinary opportunities to save money around senior health care while at the same time improving the quality of health care; but they are not things we will ever be able to do from Washington.

So why not circumvent these problems? Why not end-run them and go to the market and say, what are you charging for this basket of services, and try it in a few markets and do it in a timeframe that will give us the information to move at the pace we must, or this system will go bankrupt and we will not have the choices that we need?

Ms. WILENSKY. Well, I think—if I may make the first response, Mrs. Johnson, I think it is consistent with what Stuart Altman and I have said, that the difficulty is that there hasn't been an obvious market to look to, particularly as it relates to seniors. The idea behind competitive bidding as a strategy to set the amount that you pay is not to tie it to what was spent on average under fee-for-service in an area for Medicare beneficiaries. We could protect ourselves as a program by putting an upper limit there, but otherwise basically let markets establish what they are willing to pay in

order to provide a Medicare coverage service package to the people in that area.

In some areas of the country where you have established Medicare Programs—for example, Portland, Oregon has over half of its seniors already in HMOs and managed care, there is no question in my mind, you could do competitive bidding as fast as you could put the office in place.

Mrs. JOHNSON. They do that in Oregon without our doing the Federal risk adjuster. A lot of things that are happening are happening without our fixing the problems in the system, and when 74 percent of seniors live in markets where there are managed care choices, why do we have to fix all the problems you point to? Why can't we go around them and gradually wipe them out?

Ms. WILENSKY. Competitive bidding in the areas where there are a number of HMOs is something that you ought to start quickly. There are parts of the country, of course, where you won't have enough entities to start, and there is a problem in risk selection. Let me try to explain why.

Even if HMOs are not actively selecting healthy risk—I believe Stuart, that there are a couple of bad apples out there—in general, I don't think HMOs are going out and actively shunning certain groups and attracting others. But the problem is, if it turns out that you get the healthy folk in your HMO and the HMO down the street gets the sick people, there will be financial reward or penalty if you don't make an adjustment. That is, if you get part of the 10 percent of the population that spends 70 percent of the money, or the 1 percent that spends 43 percent of the money, you will either make a bundle, if you are paid on average, or lose a bundle if there isn't some adjustment to the premium. If you have any linkage to what is going on in the fee-for-service system—which I hope you get rid of, then you get caught there in case the people who are left are either sicker or healthier than average.

So as long as you have choices around, this is not just a Medicare problem. This is a problem any time you have choices in the system.

FEHB, for example, the public program for Federal employees, faces a risk problem if disproportionate numbers go to a particular plan.

I think we can make some inroads there. I am not going to recommend you stop until we fix the problem. I think we can do better than we have if we give it a little more serious attention. But I am all with you; competitive bidding, which means going to the market, is great.

Mr. ALTMAN. Let me add a couple of things to that. I am convinced that if you don't seriously look at risk adjustment, 3 to 5 years down the pike, a new group of people are going to be sitting at this table telling you some horrendous stories; and the reason why I say that is, if you look at the insurance world, the fee-for—the private insurance world, they are very sophisticated, experienced raters. I mean, we can't be naive. There is so much money at stake here, the ability to make money in—and these are smart people. The ability to make money by carefully crafting techniques to have less sick people is such an incentive out there, it is almost too tempting.

Now, this is not saying these are bad people. This is not saying these are un-American. This is what incentives do. So I caution you as strongly as I can, do not be misled by the plans that talk to you. They honestly went into this market, many of them have been in the market for years. They had a social mission and an economic mission. They didn't experience rate. Some of them are getting badly beat up in the HMO world because they are finding themselves with adverse selection relative to the newcomers.

You can't ignore incentives. That is why we want to change, because the old set of incentives in fee-for-service killed us. You could create another set of incentives that would kill you, and then the groups are going to be here talking about profits being made and other firms going broke, and I think most managed care plans would want to have a fair risk adjuster so they don't get hurt.

Mrs. JOHNSON. Thank you. We will pursue this at other times.

Chairman THOMAS. Just two points before I recognize the gentleman from California.

Stu, you and Gail talked about the problem in the way in which teaching hospitals are funded.

Mr. ALTMAN. Yes.

Chairman THOMAS. Perhaps the HMOs are not passing through the money given to them to those institutions, like the more traditional structure. You just talked about a problem in terms of risk adjusting and rating within Medicare. It just seems to me that both of those problems are probably better addressed in the larger arena of health care reform, like fundamentally changing the way in which teaching hospitals are reimbursed. Then you don't worry about it passing through cleanly on a Medicare structure; and we deal with the way in which insurance is sold and the way in which ratings are determined. If we deal with that on the health care question, we then will have solved it. And I just am a little concerned about how much weight we have put on the back of Medicare to carry changes in the health care arena that probably would be fairer and better met on a broader based change, more fundamental change.

Mr. ALTMAN. I agree with that, but I think back to a discussion I had with Mr. Cardin several hearings ago. And he chastised me, and I think appropriately so, for a catch-22 environment, which is, OK, I buy that. But suppose you take the extra funds out of Medicare, what happens to those institutions? And so, in general, I supported where you were.

I think in the bigger picture, it is a small issue. It is not a small issue in Los Angeles and in Boston and New York; and it is not going to be a small issue when Medicare goes to 50-percent managed care.

So, yes, in a theoretical sense, I would much rather see it in broader reform, but I don't think you can ignore it in Medicare because now Medicare is becoming the dominant form of extra payment for these teaching hospitals.

Chairman THOMAS. I think your response is well taken. So what I need to do then is, in crafting a solution for Medicare, make sure that it fits into the larger health care plan that will either precede or follow it. So one or the other, the two have to be compatible. I prefer doing the larger, which gives us a broader——

Mr. ALTMAN. Mr. Cardin walked in and he hasn't heard, but I apologize.

Chairman THOMAS. The gentleman from California.

Mr. STARK. Thank you, Mr. Chairman. I will just follow up on what Stuart said.

We had—a year or two ago, Stan Jones, who was then a private consultant to insurance companies, consulting with him on how to find, within whatever was reasonable, healthy people, or how to avoid unhealthy people—and I can't remember where it was, perhaps in my own district; but as somebody said, you want to try it, try signing up one of these Medicare Select or Medicare HMO plans over the phone. Just try. Try and not go to a meeting which you have to come to before the company will sign you up. Where is the meeting? Not near public transportation. Why is it at some hotel, so that they are sure the people who get there can drive.

There are all kinds of subtle little ways that you exclude—now, they are not so crass as to put it on the third floor and not have an elevator, but—in which case I wouldn't be able to sign up—but there is a cottage industry out there which saves these insurance companies tons of money in doing it.

I would ask one question of Stuart and Gail. In all this selection, if in areas where there is wide usage—in my district, 70 percent of the people belong to staff model HMOs, 70 percent of the residents, not just Medicare. If one had community rating, open enrollment and no medical underwriting strictly enforced, would you not then, just through service, would there not be any risk selection? It would seem to me you would just get an average of people—Gail is saying no.

Ms. WILENSKY. The reason is that unless people evenly distribute themselves among the competing HMOs in your district, and for reasons that have nothing to do with what you have done, you happen to get 20 percent more of the AIDS patients or the chronic diabetics or the potential Alzheimer's or whatever, and you get paid on average, you will get hurt. As long as there is choice among plans——

Mr. STARK. Somebody said that if you got more than a couple of thousand members at some level, that this—we were discussing this in self-insurance—at some level, that selection sort of evaporates as you get to be a fairly big plan.

Ms. WILENSKY. I think that there is less of a problem the larger the group. That is why it has always been harder to do bundled payment for doctors or outpatient services than it is for the inpatient sector. Because health care spending is so concentrated, I really believe risk selection and risk adjustment, which I am a little more confident we can do, is a problem. But the bigger the group, the smaller the problem.

Mr. STARK. Is there anything wrong with requiring nonage-related premiums for seniors? It seems to me to be—well, first of all, it prevents chicanery among salesmen for lowballing seniors into coming into a plan, then kicking up the premium as they get older. But if you follow the fact that they will get sicker and more expensive as they get older, and perhaps they are on limited assets, they will dissipate that as they get older, that if the price they have going in at 65 remains the price throughout their lifetime, that

that would be a better system than allowing age bands and to kick up the premium, and also a way to prevent what I think are rather unscrupulous sales practices of starting low and then, when you get to be 70 or 75, having rather severe increases.

Does that disadvantage or does it offend any of you to say perhaps we ought to require that as a social benefit?

Ms. WILENSKY. Well, it would hurt a plan that was an established plan in an area that would get older and older people who, other things being equal, will be predictably more expensive; and that, of course, doesn't allow them any kind of package——

Mr. STARK. It seems to me—you are saying after they open up?

Ms. WILENSKY. Yes.

Mr. STARK. I am saying, when people move into Medicare, this is your largest enrollment population, the people that become 65 each year; they mature into these plans, and rather than allow—that is where the competition occurs among plans.

If you allow one plan to lowball—and in California, for instance, AARP is the only one with a nonage-related premium, and they are a couple hundred bucks higher for the same Medigap policy at 65. But pretty soon, if you sign on to some of the other plans, by the time you are 75, you are paying a whole hell of a lot more; and it really, I don't think, is—I don't think that is good for the consumers.

I don't think it hurts Medicare, and I think it prevents possible chicanery to just say, wait a minute, you set a rate. Now, if you come in later, that is OK, but it becomes the rate for the rest of your life. I mean, you don't let them kick up the rate every 5 years.

Mr. ALTMAN. I want to make a distinction between the rate the individual pays and the amount paid by the program. I think you need to risk-adjust the amount paid by the program because the plans need to be protected. I mean, I would have to——

Mr. STARK. Why do we have to protect the plans? Why do we have to protect the plans? I am not so sure.

Mr. ALTMAN. Because I think they are going to wind up having to provide more services, and you don't want to—you don't want to underpay them for legitimate needs of older seniors.

Mr. STARK. You are not into this market business story. That is not our job. They are supposed to go broke. That is what takes the inefficient ones out and the efficient ones make a big profit.

Mr. ALTMAN. This has nothing to do with efficiency. This has to do with legitimate service that an 85-year-old frail person might need that a 65-year-old doesn't.

So I think it is——

Chairman THOMAS. Go easy on him. He is new to this market concept.

Mr. STARK. I am learning.

Mr. ALTMAN. Let me jump.

Mr. Chairman, there was one piece that I don't have in my testimony that also blew my mind, and I apologize for this; but what you said, Mr. Stark, is absolutely correct.

The Medigap business is also leading to substantial distortion. If you buy fee-for-service Medigap versus buying a Medigap policy from a managed care group, you wind up paying substantially more for the same risk in the fee-for-service because in the fee-for-service

are the disabled, are the renal patients and everybody else who can buy an average Medigap plan; where in the managed care plan, they are not there.

So there are distortions that are currently building into the Medicare Program, and it varies of course by area.

I think the Medicare Program is fast moving away from its basic premise, which is to provide a national benefit package of roughly comparable rates around the country; and it is distorted twice, at the Medigap policy and at the way the government pays through the AAPCC.

Mr. STARK. Thank you, Mr. Chairman. Thank you.

Chairman THOMAS. Interesting.

Let me say that everybody has subtle ways of selecting, and the gentleman from California indicated drivability to the hotel. I would say if I was an association looking for would-be seniors I would begin mailings to individuals age 50 and up—obviously they are people who plan for the future, which, by definition, are somewhat atypical, and they have 15 years of planning for the future before they become available for the plan.

Mr. ALTMAN. Absolutely.

Chairman THOMAS. The gentleman from Louisiana.

Mr. MCCRERY. Thank you, Mr. Chairman.

Just a quick question to you, Dr. Altman. I think you said that when you look at seniors that are served by the VA system and by DOD, you find that their costs or their expenditures are 3 to 7 percent higher?

Mr. ALTMAN. I may not have made myself clear.

Many seniors avail themselves of services that are provided free to them by the VA and the Defense Department, so they therefore use less services from the regular Medicare fee-for-service or managed care world. But when it comes time to calculate the AAPCC in the area, they include in the denominator all of the people, including those that use the DOD and the fee-for-service. As a result, in some areas, you get a distortedly low——

Mr. MCCRERY. I see. I misunderstood.

Mr. ALTMAN. No. I didn't say it correctly. I can see why you misunderstand it.

Mr. MCCRERY. That explains it. Thank you.

Dr. Altman, you talked about distortions that are in the current system. It seems like every time we talk about Medicare, the subject of distortions comes up; and it seems to me that many of those distortions are caused by the government trying to direct one thing or another, or the government trying to create incentives, or the way the government designs a benefit package or a payment system or whatever. It is almost a catch-22. You try to fix something here and you create something over there, and you get these distortions because of government policy.

I would like to find a way to minimize the government's influence in the Medicare system; and it seems to me that in order to do that, we are going to have to follow the President's advice, which is to address the health care system at the same time you address Medicare in terms of reform.

Do any of you have any ideas on that? Do you agree with that, and if so, is there a way that we can work to blend the Medicare

system with the private system in a way that minimizes distortions and still provides quality care for our senior citizens?

Mr. ALTMAN. I support your comments in general, but I would add the caveat that it is not only the government that gets caught in this problem.

I have spent a few years on and off working with the large autos. General Motors and Ford got really beat up when they went into the managed care business because they wound up with problems not unlike what happened to the government. They had their less sick people go into the HMOs. The HMOs were collecting average premiums. They thought they were saving 10 percent. When they finally added up the bottom line, they found that they were paying a lot more because the people who weren't in the HMOs were the sicker ones and so they, too—you know, when you get—I think what we are dealing with is bigness and big averaging creates problems. So I agree with you.

My own view is, we need to move things down into the community level. We need to develop mechanisms that are much smaller, and I do believe Medicare needs to be incorporated into the broader issues of reform. How that is done is, as you know, a very complicated, not-agreed-on strategy, but basically I agree with you. I think it is bigness and averaging that creates these problems, and of course, the biggest of all is the government, so it creates the most problems.

Ms. WILENSKY. Let me try and expand a little on this issue. While there are problems outside of Medicare and Medicaid that need to be addressed, that I wish had been addressed in the last 2 years, but weren't, I think that the public programs are different because they use public moneys. We need to address them with an urgency that can't be avoided because of the pressures that they are putting on the Federal budget and attempts to reduce government spending or government involvement.

In the case of Medicare, if you wanted to try to reduce government involvement, you could try to set the amount that Medicare will pay at whatever price is available to cover Medicare-covered services as they exist now, hopefully, with some risk adjustment so you take care of those that are predictably sicker—and allow people to do as they will in buying various products—HMOs, managed indemnity plans, and regular, old, expensive fee-for-service, which means they will have to put in some more money.

But to have the Medicare amount reflect the cost of a low-cost provider of Medicare services and what other people want to buy is something they can buy and add on to that.

As I think you know, I am also intrigued by the notion of having a medical savings account catastrophic option as a one-time option when you turn 65. I think the selection gets very difficult when you get over 65, but to give people choices, Medicare should decide on a competitively bid type of model that reduces the involvement of government in those little areas.

Now, you still have to worry about risk adjustment and you will still have to worry about making information available and making sure that the plans aren't fooling around in some way. But I think that would make a huge difference in the Medicare market, whether or not you are willing to take on what is going on in the private

sector. A number of us have ideas about how we would like to improve the way the private sector works in terms of subsidies that exist and distortions; but frankly, I think Medicare is so much money and is in now a real financially fragile position that you just can't avoid trying to do fixes here, whatever it is you do elsewhere.

Mr. MCCRERY. Well, I would like to explore this more, but my time is up. Maybe we will get back to it.

Chairman THOMAS. I think that is the answer.

Mr. MCCRERY. That is the answer, Mr. Chairman, but it is only part of the answer. I mean, I don't see how we do what Dr. Wilensky said without some private sector reforms, insurance reforms, and so forth.

Ms. WILENSKY. I don't want to discourage you from doing it. I just don't want you to believe that if you can't do the second, you would have no choice with regard to the first. I think you can't not do Medicare changes because of the pressures in the budget.

Mr. ALTMAN. We are both concerned about that. You can't leave Medicare unreformed.

Mr. MCCRERY. I agree. But if we do Medicare the way you just suggested—which, by the way, is almost word for word what I have suggested to some other folks—then I think we have to do some private sector reforms. I think you have got to mesh the two; otherwise, you have the same budgetary problems that we have got right now.

Chairman THOMAS. I do think the problems with Medicare are the same in the larger health care arena, and therefore, as long as we keep the solution the same, it makes less difference to me which one moves first. I just don't want a fix for Medicare that is artificial or doesn't also address the larger concerns. You have got to keep them together, and I don't care which vehicle moves it first, as long as the solution is what is agreed upon for both.

The gentleman from Nevada.

Mr. ENSIGN. Thank you, Mr. Chairman.

To follow up a little bit on what Mr. McCrery has talked about: In Nevada, I held a Medicare task force, had HMOs at the table and hospitals, teaching hospitals, physicians, AARP was there. We had really a very, very diverse group, trying to get all the different opinions at the table at the same time, trying to come up with some possible solutions, and we will be holding these at various times during the summer.

One fairly well agreed upon problem in the whole Medicare situation is HCFA. Virtually everybody said that what would be a great place to start, is to eliminate HCFA in whatever way that we could. But I think that brings up something that Mr. McCrery talked about, and that is, the government is so involved with the system and micromanaging the system that it creates a lot of its own problems.

The reason I wanted to pursue that is to just continue the dialog on this, do we foresee perhaps assigning risk to different individuals based on their health status, which is being talked about over on the Senate side as well as talking about some vouchers.

You know, based on your risk, now you get a voucher and you go out there in the marketplace and you buy your own health care coverage. Whether that is at 65, the medical savings account, or on

a yearly basis you choose managed care. Whatever it is out there that you are choosing, the government is assigning the risk, and, therefore, an amount so that the insurance companies don't get burned by the risk when they get all the bad patients into their pool.

Do you see some kind of answers along those lines?

Ms. WILENSKY. I think it does some of it, but I would see structuring it a little different: Believe me, in the 2½ years I was at HCFA, I heard about every evil thing ascribed to it you could imagine.

I believe in having Medicare become an equivalent kind of payer. That is what I was talking about—having a bid that reflects a judgment about what it would take to have the services provided in a low-cost plan or in an efficient way. That is what the government should do. I don't know that you necessarily have to give a voucher to the individual.

What you need to do is have a way that individuals receive information about the health care plans in that area, and that is something I think HCFA could do. If it is doing less about paying line item services, it can provide information about the plans that are in the area and make sure a payment adjustment is made so that the plans that get the chronic diabetics or the serious cancer patients get an additional premium and everybody else gets a little less.

You don't have to make adjustments for all 37 million people on Medicare. What you have got to do is make some adjustments for the major classes of different users, and so it is like having an individual voucher. I don't know that you literally have to have that kind of structure.

Mr. ENSIGN. It is more of a concept.

Ms. WILENSKY. What I would see HCFA doing is providing information to seniors about satisfaction, about outcomes measures, about making sure that the plans are behaving appropriately; getting information; moving to annual or some other more structured enrollment; and getting more and more away from being the payer on a line item basis.

Even for people who want to go into fee-for-service plans, that is fine. They just get a payment from the government that probably isn't going to be enough in most areas to cover an open-ended fee-for-service. They add to it and go to their plan.

So I see a different function over time that HCFA would take on. I guess the bad news is I don't see HCFA going away for those that had that as one of their main goals.

Mr. ENSIGN. I was just dreaming out loud.

Ms. WILENSKY. Reduce the level of involvement, though, for sure.

Mr. ALTMAN. Let me add something that the private sector is doing that I think HCFA or some other agency needs to do, and that is, yesterday it was announced that many of our largest corporations, Sears and Merrill Lynch and American Express, are forming into a consortium and opening up competitive bidding nationwide for managed care plans to provide a whole battery of information—not only prices, quality of the care, availability of the care. And that seems like it makes so much sense.

As a worker, I want a company that, first, has done some screening, and second, I can go to at some point to protect myself. I don't think you would be able to withstand hundreds of thousands of seniors coming in here and bombarding you if they get really hoodwinked all over the place.

So you need—I agree with Gail. You need somebody out there to do what is now being done for enrollees in the private sector, these HEDIS reports and stuff like that. With that information, then you can have a much freer system of selection. Even the Federal employees are doing the same thing. So that is more along a model of what HCFA could do.

Mr. ENSIGN. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman from Nebraska.

Mr. CHRISTENSEN. I would tend to agree with my colleagues from Nevada and Louisiana that if there is one major problem in this whole dilemma, it is HCFA.

To what degree does Medicare inform beneficiaries of the managed care options available?

Ms. WILENSKY. Not at all.

Mr. CHRISTENSEN. At all?

Ms. WILENSKY. Not at all. If you will forgive me, HCFA is administering the program that is basically in place by legislation. I agree with a lot of the complaints of your seniors and your physicians, but it is the program that was legislated in place. Excuse me.

Mr. CHRISTENSEN. We will change that.

No information at all?

Ms. WILENSKY. None. None.

Mr. CHRISTENSEN. Pretend that I am a Medicare recipient. I call HCFA. I can't find out any managed care plans in the area? I can't find out any premium information, additional benefits? I can't find out any information?

Ms. WILENSKY. Well, there is a group that has worked with HCFA, and I can't remember what it is called. There is a group that is a public group that has been working with HCFA to make information available, and of course, as a result of the changes in 1991 law, the kinds of options that are available under Medigap are severely restricted.

So HCFA doesn't have as part of its mission, or any funding, to make information in general available about the managed care plans; but there is some structure now because of the changes that were put in law about what is available. But nothing like what I think should exist.

Mr. CHRISTENSEN. What do you think should exist?

Ms. WILENSKY. What we were talking about, which is really the sort of report card notion of what is out there, what it costs, what kind of benefits you get, consumer satisfaction, enrollment, disenrollment and anything we know about outcomes.

Mr. CHRISTENSEN. How many HMOs in an area do you think it needs to put together a competitive-type structure, competitive bidding?

For example, I am from Nebraska. Two-thirds of my State is more rural than urban. How would it work in the western United

States, in the less urban areas, what you are proposing, in terms of ideas?

Ms. WILENSKY. I think what you will see happening are two things. The first is you will find some of the groups coming in that you might not expect to be in your backyard. For example, the Mayo Clinic has been running around northern Iowa setting up relationships with primary care physicians, relationships to have people go back to the Mayo Clinic and, if needed, to Methodist Hospital.

The Loveless Clinic in Albuquerque has been doing similar arrangements with regard to physicians in rural New Mexico. So for one thing, I think you may find over time you may have more company in your areas than—even in the western parts of your State than you thought.

The second thing is that a number of States have used primary case management as trying to bring together a coordinator so that you don't have completely a la carte fee-for-service medicine; and again, you can get a package of services that would then get put together and bid for.

So I think we need to recognize that for the frontier parts of the country—the Dakotas, Montana, and Wyoming—that there are different ways of structuring this than if you are in Los Angeles or the bay area. But I think that in both the entry of groups that are nearby will be greater—I mean, there are a lot of those activities, plus spins on primary case management, to allow for some level. But in areas that are sparsely populated, you know, two or three groups will be all you will have.

Mr. CHRISTENSEN. I guess one thing I will probably remember the most from this panel today, Dr. Altman, is your response to Mr. McCrery's question and saying that we are not talking about efficiency here. And I guess someday maybe we could—someday maybe we will get to a government-run program that is somewhat efficient.

Thank you.

Ms. WILENSKY. You have got to change the incentives first.

Mr. ALTMAN. You have got to change all those incentives.

Chairman THOMAS. Let me underscore a couple of points. Chairman of the Budget Committee Kasich and I sent, in February 1995, a letter to Bruce Vladeck at HCFA asking him once again to provide us with any kind of a listing of the information sent out about managed care options. HCFA has not gotten back to us on that. We are also looking at some language right now from OBRA 1990 where I think we even set aside some money.

And it just seems to me a little bit unfair to constantly point out that HMOs are out there sophisticatedly avoiding risks in the recruitment of seniors when a simple foil to that would be to provide a one-stop-shop access for information about them; when, in fact, I believe it is more simply going out there looking for customers and the manner in which you look for customers.

Whether it is a third floor hotel that you have to drive to or a sophisticated mail program to professionals at age 50, those are marketing choices that I think are, after the fact, damned as selective procedures, when I think one of the fundamental faults—and another—we have talked about the number of catch-22s we have

here—is that the Federal Government isn't actively pursuing an informational directory to have people call up an 800 number and find what is available in their area.

Ms. WILENSKY. Mr. Thomas, now that you mention it, it strikes me that there was some money set aside, and perhaps you could ask whether that is available now in the Social Security offices or not. It strikes me that that was supposed to be in place all in one stop. Of course, having the Social Security Administration no longer part of HHS is not going to make any of that coordination easier.

Chairman THOMAS. It is not easier, but we are going to run it down because as this discussion went on, in my head, I said, wait 1 minute, I thought we had done this once. We are going to follow up on that.

The last question I guess I will ask you is one that you can't answer, but I want you to begin thinking about it, and again, it is partly the chicken-and-the-egg because you spent so much time. And Mr. Ratner, if you can get in on this from the angle of your research as well.

Both of you, Drs. Wilensky and Altman, spent so much time on the failure of the AAPCC to be a reasonable tool in measuring value—and we talked about small percentage shifts into managed care—to what extent is the failure to move more rapidly—even in areas where managed care is clearly the dominant choice, to what extent is it the failure of the funding mechanism? The primary reason?

Ms. WILENSKY. No. I would put it the secondary reason. The secondary reason is that the elderly have very little reason to leave the a la carte, open-ended entitlement fee-for-service system.

I don't think the AAPCC is a trivial problem. I think that is why Medicare doesn't get much in the way of savings. But, for me, the most serious problem is the lack of incentives for the elderly, the reward to choose wisely. I don't know what——

Mr. ALTMAN. I would agree with that. We did not see a rapid buildup in managed care in the private sector until employers changed the incentive structure substantially, not marginally, so that it became more and more expensive to individuals to stay in the program that they traditionally had. It didn't force them, although now you get to some employers that your only options are between managed care A, B or C. But in the transition, it moved—it flipped in the late eighties from making fee-for-service the dominant choice for many employers to making managed care the dominant plan.

You have got to be more careful with the seniors, but I support Gail. That is the primary reason.

Chairman THOMAS. So the system that is driving us bankrupt that we are going to try to get people to move out of voluntarily is actually the wisest dollar choice that they could make?

Mr. ALTMAN. Yes.

Ms. WILENSKY. They are acting very rationally.

Chairman THOMAS. And the failure to change that system fundamentally?

Ms. WILENSKY. Make some of those changes, either because they are—in the best of all worlds, they are using a lot of other people's

money in an open-ended entitlement. That is a very nice place to be.

Mr. RATNER. There is an additional aspect of that also, which is that particularly the elderly feel what many people feel, that they are attached to their primary care physician. That becomes a more acute problem as people age, particularly if there are chronic diseases that are present.

So while the financial element, the financial choices that they face, is an important thing to consider and is going to affect some people, we do have to remember that this is a somewhat different population than the younger employee population. It is a tougher market, really, to draw people in voluntarily.

The second thing is that—what Dr. Altman said is very important, there are many things that employers do as sponsors that are much more structured than Medicare and the Federal Government have done vis-a-vis Medicare beneficiaries and, perhaps, are contemplating. That structure, while not necessarily compulsion, really gives an extra push to people in the private sector in the employee population. So there are some different things going on there.

Chairman THOMAS. I was looking at a chart in the ProPAC structure. The majority of people in California are in managed care programs. We are really negligent if we don't create a system that carries over the workplace experience, which in the sixties was fee-for-service, and create a wall to a certain extent for those people who were in the system and try to incentivize them into the newer system.

But to the degree we don't inform them, we don't have a payment system which is rational. We are, in fact, penalizing ourselves and the taxpayers by getting people into Medicare basically as a fee-for-service program, when they were in a managed care program in a place of work.

Mr. RATNER. Yes. There certainly are things that can be done—or can be considered—so that people who have been in managed care organizations as employees can age in and remain in Medicare. But part of the problem there, that again we have to recognize, is that currently the Medicare managed care program is largely an HMO program, whereas the thrust of managed care in the private sector has been heavily toward looser forms of managed care.

There are some things that we need to pay attention to in thinking about the choices that the beneficiaries have, so that if we are looking for the kinds of gains you get in the private sector, that it is reasonable then to expect them to show up in Medicare.

Chairman THOMAS. I have no interest in locking nineties Medicare into a structure which may be transitionary, as we did in the sixties. It has got to be an open-ended model to allow for movement. There is no question about that.

Let me ask you a very difficult political question. If, in fact, we are basically providing them, for want of a better term, with a chocolate sundae and the other option is plain ice cream, and we keep the chocolate sundae available and continue to try to convince them the plain ice cream is pretty good. Would you advise us to look at the possibility of closing out the chocolate sundae market on a prospective basis so that only ice cream is available?

Mr. ALTMAN. First of all, let me change your analogy just a little bit.

Chairman THOMAS. Good. I am looking for a better one, one that is 25 flavors.

Mr. ALTMAN. We will stick with the ice cream because that sort of engenders a positive——

Chairman THOMAS. Ice milk versus ice cream.

Mr. ALTMAN. No. As I mentioned in the testimony, let's think of the fee-for-service as sort of a half a sundae or minisundae. The real sundae of today is to be in a managed care environment in a high AAPCC area, because you get all of these extra benefits.

So what you have are three kinds of choices. You have the fee-for-service, which is quite attractive; and then we bribe or encourage or incent—I think it is almost bribing—to put all this extra stuff on to make people move into it. So in California and Arizona, it is not surprising they are there, because they get all these extra benefits because of the way the current system is structured.

And then you have the vanilla. What are you going to do? Take away the true sundaes from the people that are in managed care in very high AAPCC areas?

Ms. WILENSKY. This is one of the areas where I don't quite agree. I agree that it is an issue we hadn't thought about, that there is a lot more variation because spending is there, but if these people weren't in managed care plans, they would be just in that regular, old, expensive fee-for-service and that would——

Mr. ALTMAN. That is not the issue. I don't disagree.

Ms. WILENSKY. I think actually your analogy is a perfectly fine one and the issue we ought to be asking ourselves—as a government and as a taxpayer, we owe providing the cost of the plain ice cream; we promised that. Those are the benefits and we ought to make sure we do it and we do it at the cheapest place that we or—not the cheapest, at a lower priced place to be able to get it.

It is—I could understand the attractiveness to you as a politician to not have the chocolate sundae out there available, but it is the wrong path for us to take. We want people to be able to choose what they want. What we have to do is have the discipline as a government to say, our job is to pay for the basics. We will do that, and if you want to buy the chocolate sundae, we won't stop you, but don't ask us to pay for it.

That is really the change in thinking, and to take away the artificial barriers, I mean, it is ridiculous.

You said it very well. People in California are aging into Medicare in plans that they have been happy with. You can't stay in that plan because when you turn 65, you must go into the fee-for-service world. You can't stay in the plan because if your employer only allows his employees or former employees in, that disallows you from being in an HMO under Medicare rules. We absolutely stop with these foolish rules, people continuing care in a seamless way as they go from being 64 to 65. Now, that is dumb, but it is going to take more than that in order to change this problem.

Chairman THOMAS. Then not even create an informational structure to find something else and have a payment system, as Stuart says, which isn't rational at all within regions.

Ms. WILENSKY. It is not a surprise why you have got a problem here.

Chairman THOMAS. Yes, Mr. Ratner.

Mr. RATNER. Just a couple of points. First, the idea of putting fee-for-service out of reach of the beneficiaries I don't think makes sense in terms of good economic logic. What you really want to do is make sure that people have appropriate incentives to choose efficient plans. Whether that happens to be fee-for-service, HMO, PPO or some new alphabet soup that comes up in 10 years, you want to have an appropriate, level playingfield there so the incentives are right, not that somebody prejudges which delivery form is best.

Point two. If you look at Boston, Massachusetts, and compare that with New Haven, Connecticut, you will find that the level of resources devoted to medical care per person in Boston is much greater than in New Haven. You can have a managed care plan in Boston that may be having a richer, more intense practice style than New Haven.

If you set up a scheme that just says, exclude one form of delivery, a fee-for-service plan, you would be saying in effect that maybe parts of the country where they do things leaner shouldn't be doing it. I think it becomes sticky there. So I just give that as a caution.

Chairman THOMAS. Well, finally, my concern is that if we do determine what is a reasonable payment structure and different styles of delivery of care have a different cost pattern, would it be appropriate to indicate that this is what is available, and if you want a different program, you pay for the extra cost, but that you could get this under a particular style—that is, provide a wide choice, but clearly certain styles would have 100-percent coverage, and if you want a different style of delivery, it would then be out of pocket on your case.

That is an option that we would be looking at, isn't it?

Ms. WILENSKY. That is I think what you need. That is what you need to move to.

Chairman THOMAS. The gentleman from Louisiana.

For the record, I think Dr. Altman nodded his head.

Mr. ALTMAN. I did.

Mr. MCCRERY. Just a quick followup to perhaps conclude this. Is any one of you familiar with the CBO study on the amount of money that the average Medicare recipient paid into the system versus the amount that the average Medicare recipient takes out of the system?

Ms. WILENSKY. I was just looking at some figures that were HCFA, and I think ProPAC has done them. I don't know that I have seen CBO's.

But basically, what I recall is that in part A, the trust fund part, the average payment in is about $8,000. The average payment out is about $40,000. So it is roughly a 5-to-1 differential. If you include the employer's share, it is then about 2½ to 1.

You get out two-and-a-half times more than what you put in, and of course, that doesn't account for part B where somewhere between 25 and 30 percent is paid by the senior and, therefore, 70 to 75 percent is paid for by the taxpayer. So it is a heavily subsidized transfer as it exists now.

Mr. McCrery. So the average Medicare recipient, at least under today's system, takes out about three times as much as he ever puts in in taxes when he was in the work force.

Ms. Wilensky. Slightly more. Slightly more. It is 2½ to 1 on the hospital side and—well, I guess 3 to 1. So it is about 3 to 1.

Mr. McCrery. Well, I think that explains where part of our problem is.

Chairman Thomas. Any additional questions?

I want to thank all of you very much. As usual, you have been very, very helpful in focusing our attention.

I would ask the next panel to come forward and this panel will consist of Stuart Butler from The Heritage Foundation and David Kendall from the Progressive Policy Institute.

I want to announce prior to the beginning of this panel that, due to a previously arranged Ways and Means Committee function, the Subcommittee will break at noon for 1 hour and we will reconvene for the third panel at 1 o'clock. So that if the folks from Arizona want to try to get a bite of lunch, we are not going to be back in until 1. I apologize, but the Full Ways and Means Committee has a preplanned meeting and function, and we are required to participate in that.

I would tell this panel, as I have the others, that if you have any written statement, it will be part of the record, without objection, and that you may proceed to inform us any way that you see fit.

Dr. Butler.

STATEMENT OF STUART M. BUTLER, PH.D. VICE PRESIDENT AND DIRECTOR, DOMESTIC AND ECONOMIC POLICY STUDIES, THE HERITAGE FOUNDATION

Mr. Butler. Thank you, Mr. Chairman, for the opportunity to testify. The discussion toward the end of the last panel with regard to incentives, I think, very nicely sets up for what I wish to address, which is the basic incentive system. We see a slow pace of HMO enrollment and other innovations of delivery in the Medicare system because of the very nature of the program, which is essentially a planned, defined benefit program.

As such, it tends to be rather insensitive to the normal process of innovation and quick decisionmaking that occurs, say, in the corporate area. Similarly, it is insensitive to the introduction of services that the elderly may want and, may be more effective to treat them.

I think as a general strategy with regard to Medicare, it is important for Congress to restructure the program, moving much more to giving control of the dollars and choice of services to the elderly, and using competitive forces among competing plans to provide both quality and price for the elderly to buy.

As a model to look at for how this might be done, I think the Federal Employee Health Benefits Program, which, of course, covers you, Mr. Chairman, and other Members of the Committee, and also Federal employees and retirees from the Federal sector, is a very good basic model to examine.

It provides good information to the elderly who are in that program. It provides a range of plans. It provides different benefits within those plans. And a method of enabling elderly Federal retir-

ees to pick plans sensibly, by the use of fairs and other kinds of marketing arrangements to deal with some of the problems of marketing that Mr. Stark and others mentioned.

If you were going to move to a system like this for Medicare generally, there are two broad changes that would be necessary. One is to move toward a defined contribution system, or a voucher adjusted by age, sex and geography at the least.

Incidentally, the former and current Directors of the CBO, Mr. Reischauer and June O'Neill, both support a move in this direction.

An alternative to a simple voucher would be some kind of credit system against the cost of premiums and other expenditures, and there are various variations that can be considered there. But the important thing is to move to a defined contribution, which is essentially in the hands of the elderly themselves to make the decision over exactly what kind of plan will serve them.

The second element which is crucial is to allow Medicare-approved plans, willing to enter this market, to compete for the voucher, much as under the FEHBP. The same kind of arrangement should occur. It must be a very open-ended arrangement to allow variation of types of services, not just HMOs or fee-for-service, but a wide choice of a continually expanding range of types of delivery to be incorporated into plans that could be offered to Medicare beneficiaries.

To be Medicare-approved, I would argue that such plans would have to meet certain basic conditions very similar to those in the FEHBP. They must show basic financial security. They must have a standardized description of their costs and services and a standardized marketing method very similar to what OPM requires for the FEHBP plans. It would be possible under this arrangement for Members of Congress, say, or HCFA, to arrange all kinds of ways of standardizing information for the elderly to pick the particular plan they wanted.

Third, there should be a core set of benefits in the plans that are being offered to the Medicare-eligible population. This should be a rather leaner core than today—principally catastrophic, hospitalization and so forth—but with a wide range of additional services that could be incorporated into any plan, and a Medisave variant could be offered as well.

And, fourth, premiums in such a Medicare-approved plan, would be subject to limited underwriting, using essentially the same principle to devise the voucher—age, sex and geography. Under this arrangement, you would see two principal effects. One is that the elderly's choice of plans would be affected by the total cost of plans and out-of-pockets, not the way in which their out-of-pocket is affected, which is the case today.

So to take your ice cream sundae analogy, it would be rather like offering either ice cream or a sundae, but saying, we are going to contribute 50 cents to whichever one you want. My kids certainly react very well to those kinds of incentives. In so doing, they are looking at the total cost of the product, rather than the specific payment that you make.

And second, of course, it would mean that the elderly would be able to pick plans that are right for them in terms of the services within them, and the relative costs and benefits. Again, this is very

similar to the way elderly Federal retirees do today; and I think organizations like AARP could fulfill the same kind of role that say NARFE does for Federal retirees, which is to help grade the plans, recommend plans and so on.

So I think a lot of the concerns associated with marketing tricks could be very simply dealt with under this kind of system.

I think if you move in that direction, Mr. Chairman, a lot of the issues that were raised in the first panel would be substantially dealt with because you would have a situation where the elderly would have a much more normal set of incentives to make decisions. They would have to take total costs into account, and there would be strong incentives for the plans to innovate in terms of the services that they provide.

Thank you, Mr. Chairman.

[The prepared statement follows:]

TESTIMONY OF STUART M. BUTLER, PH.D.
THE HERITAGE FOUNDATION

INTRODUCTION

Mr. Chairman, my name is Stuart Butler. I am a Vice President at The Heritage Foundation. I appreciate the opportunity to address the committee on structural reform of the Medicare system. I emphasize that the views I express are my own, and should not be construed as representing any official position of The Heritage Foundation. In addition I should note that my Heritage colleagues John Liu and Robert Moffit assisted me in the preparation of this testimony.

Designed to operate as a federally run health insurance program for America's elderly, Medicare was heralded by proponents to be a "[h]istoric measure and a fiscally responsible bill."[1] However, the Medicare program is now essentially bankrupt and the continued quality of Medicare services is in doubt. According to the 1995 Trustees Report, if Medicare is not reformed the cash flow of the HI trust fund (Part A), which finances hospital benefits for the elderly, will go into the red in fiscal year 1997 and the fund will run out of money and become insolvent in the year 2002.[2] The Report then provides some sobering information on how payroll taxes (which finance the HI program) would have rise to keep the program afloat. "To bring the HI program into actuarial balance even for the first 25 years",[3] a new 1.3 percent payroll tax would have to be added on top of the current 2.9 percent Medicare payroll tax. Based on the Trustees estimates for revenues under the current tax rate, this would raise payroll taxes — and hence raising the cost of employing Americans — by an estimated $263 billion over five years and $388 billion over seven years. For a worker earning $45,000 per year, it would mean an additional payroll tax of $585 per year.

To achieve long-term actuarial balance of the HI trust fund without reforming the program — that, is to put it on a *permanent* sound footing —an immediate additional payroll tax of 3.52 percent would need to be levied top of today's 2.9 percent rate. That would raise taxes by $711 billion over five years and $1.050 trillion over seven years. The payroll taxes of a worker earning $45,000 would increase by $1,584 per year.

Moreover, this shortfall is only for the hospital program. Part B will require a rapidly increasing subsidy from general revenues to continue paying for services. "Growth rates have been so rapid," explain the trustees, "that outlays of the program have increased 53 percent in aggregate and 40 percent per enrollee in the last five years. For the same period, the program grew 19 percent faster than the economy despite recent efforts to control the cost of the program."[4] With the trustees' "intermediate" estimates of future program growth, the annual taxpayer subsidy will grow from an estimated $38 billion in this fiscal year to an estimated $89 billion in five years time and $147 billion in FY 2004.[5]

Trying to hold down Medicare's costs through price controls on health providers and stringent regulations is no answer. Not only has this strategy failed to control costs in the program, it encourages physicians and hospitals to "game" the government to make an adequate living, rather than properly serving their patients. Moreover, price controls have

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[1] House Speaker John W. McCormack (D-MA), during floor debate in the U.S. House of Representatives on April 8, 1965.
[2] *1995 Annual Report of the Board of Trustees of the federal Hospital Insurance Trust Fund*, pp. 2,8.
[3] *1995 Annual Report* [HI], p. 27
[4] *1995 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund*, p.3.
[5] *Ibid.*, p. 9

shifted costs over to the private sector, driving up premiums for working individuals and families.

Instead of trying to tighten the controls and regulations in the current system, the proper reform is to create a very different dynamic and set of incentives to drive the Medicare program. Specifically, the bureaucratic, standardized command-and-control structure of today's Medicare must be replaced with consumer choice of competing health plans offering different benefits. This is the same dynamic that has allowed health costs to be brought under control while improving quality in the private sector -- and in the government-sponsored health plan enjoyed by Members of Congress and other federal employees.

The way to achieve the same results in Medicare is to reform the Medicare program by patterning it after the existing Federal Employee Health Benefits Plan (FEHBP), which covers roughly ten million federal employees, families, retirees, including present and former Members of Congress. Under this new Medicare program, perhaps renamed the "Medi-Choice" program, Medicare would become a *defined contribution* program instead of today's defined benefit program. Making this change would give America's seniors unprecedented opportunity to choose their own health plan and range of benefits, just as retired Members of Congress and other federal retirees do. Under such a system, and unlike today's Medicare program, the nation's elderly and disabled could choose sound health insurance plans from a variety of different managed care and fee-for-service arrangements. And retirees could choose coverage for services not covered by today's standardized Medicare program -- such as a prescription drug benefit -- by accepting, say, higher copayments for other covered services. One of the great ironies of the Medicare debate is that those who oppose reforms are in practice denying the elderly the chance to receive many basic medical services that are available to working Americans and even the indigent.

The key financial difference is that the government would make a defined financial contribution to the plan of the retiree's choice, rather than reimbursing each Washington-approved service according to a fee schedule that defies comprehension and ignores market realities. Doing so would mean the same incentive in the reformed Medicare as it does for federal retirees in the FEHBP: encourage beneficiaries to pick plans with the best value for money, pocketing part of the savings for choosing more efficient coverage. That incentive has enabled spending in the FEHBP to increase at half the rate of Medicare. And this year, federal workers and retirees were treated to a reduction in premiums averaging 3.3 percent. Introducing that incentive system into a reformed Medicare program would save hundreds of billions of dollars over the next decade, putting the program on a sound financial footing so that it can serve both today's elderly and the next generation of Americans.

Congress in reality only has two choices when considering the future of Medicare. One choice is for Congress to make no significant change in the way in which Medicare is run by the government, and to try to pay for future trust fund shortfalls by raising new revenues through higher payroll and other taxes, or by diverting money from other programs. This means Medicare survives only by draining money away from the rest of the budget or by raising taxes.

The second choice is to change the way Medicare is run, so that benefits are delivered more efficiently, avoiding future tax increases or a diversion of money from other programs. Making the program more efficient would not reduce the financial burden Medicare will place on the next generation, but it will also improve the quality of benefits and the choices available to America's senior citizens.

HOW TO REFORM MEDICARE

In grappling with Medicare's emerging fiscal crisis, Congress should pursue both short term budgetary measures and a long-term strategy of structural change. Short-term measures are needed to deal with the injustices and glaring shortcomings of the program. But long-term structural reform is needed to deal with the structural financial problems of the program and to improve the quality of care for America's seniors. Moreover, Congress must help to deal with the public confusion about the status of the Medicare

system and the purpose of reform. So Members of Congress must educate the American people about the true dimensions of the problem, including the potential tax burden facing working Americans if action is not taken. This last task can be accomplished in two ways:

First, Congress should order the Health Care Financing Administration(HCFA) to notify America's 37 million senior and disabled citizens that their Medicare hospitalization program is facing bankruptcy as early as 2001, according to the Medicare Trustees Report. To keep the program going without reforms, HCFA should explain that billions of dollars will need to be taken from the paychecks of working Americans or diverted from other programs.

Second, Congress should order HCFA to inform the elderly that the premiums they pay for their Medicare supplementary insurance program (Part B Services) represents only 25 percent of the premium income for those services, and that their children and grandchildren, young working families, are paying the bulk of these Medicare benefits out of general tax revenues. Most elderly are under the erroneous impression that they are paying the full cost of their Medicare benefits. The truth about the financial condition and circumstances of the Medicare system will only improve the quality of the necessary public debate.

Short-term Reform of Part B

Congress should act immediately to reduce the heavy taxpayer subsidy of Medicare's Part B premiums.

Option #1: The simplest, though not necessarily the best, option would be to restore the premium to the original 50 percent level. This could be done in a gradual, phase-down of the current level of taxpayer subsidies at five percent per year over a five-year period. This change would save taxpayers approximately $74.7 billion over the next five years.[6] By financing one-half of the Part B program costs, Members of Congress would thus return to the spirit of the original 1965 "contract" with America's taxpayers.

A reduction of the taxpayers' subsidy in Part B would encourage many enrollees to compare the costs and benefits of more efficient private alternatives with the cost and benefit of the Part B program. The more the subsidy is reduced, the more level would be the playing field between the private sector plans and the government plan. The elderly would have incentives to choose more efficient plans in the private sector. The likely result: not just a reduction in the subsidy but also a significant reduction in the gross budget outlays for Medicare Part B.

One problem with simply reducing the subsidy across-the-board is that it would impose some hardship for many lower-income Americans yet it would still continue a taxpayer subsidy to the affluent (though it would reduce that subsidy). It would also raise the cost to states of enrolling in Medicare some individuals also on Medicaid.

Option #2: An alternative would be reduce the current subsidy as income rises, and perhaps raise the level of subsidy for the elderly with very low incomes. The savings achievable from such a change would vary widely, depending on what method of means-testing was introduced. At, say, $65,000 adjusted gross income for individuals and $85,000 for couples, the subsidy might be phased out in increments of three percentage points per $1,000 of income above the threshold. The full premium would be paid by individuals above $98,000 AGI and couples above $118,000 in AGI.

Not a Tax. Contrary to what liberals in Congress may say, an increase in the Part B premium is *not* a tax increase, but a reduction in a direct subsidy. It is not a tax increase because the Medicare Part B program is a voluntarily chosen service from the federal government that can just as easily be provided by the private sector. Part B is a subsidized commercial service provided by the federal government in competition with the private sector. If Members of Congress believe it necessary to give high levels of subsidies to enrollees in the program, those subsidies should be targeted to those elderly

[6] This, and other short term budgetary proposals for dealing with the Medicare system are discussed in Scott A. Hodge(ed.) Rolling Back Government: A Budget Plan To Rebuild America" (Washington, D.C.: The Heritage Foundation, 1995).

citizens who cannot afford an acceptable level of physician services and other services now available under Part B, not to everyone over 65.

A POSSIBLE MODEL FOR LONG-TERM REFORM -- THE FEHBP

Members of Congress searching for an alternative model for reforming Medicare do not have to look far. For well over three decades, Members of Congress and federal employees -- and federal retirees -- have been enrolled in a unique consumer-driven health care system called the Federal Employee Health Benefits Program (FEHBP). Unlike Medicare, it is not run on the principles of central planning and price controls. Instead, it is based on the market principles of consumer choice and competition. Starting enrollment in 1960 with 51 plans for the federal workforce, there are now over 400 private health insurance plans nationwide, ranging from traditional indemnity insurance and fee-for -service plans to plans sponsored by federal unions and employee organizations to various managed care plans, including Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). In the Washington, D.C., metropolitan area, half of all persons with health insurance are covered by one of the 35 plans competing in the FEHBP.

The FEHBP works on entirely different principles from those in Medicare. For one thing, Medicare is a **defined benefit** program, meaning that each enrollee has access to a specific set of health services which are then paid for in total or in part by the federal government. The FEHBP, on the other hand, is a **defined contribution** program, in that the government agrees to provide the federal worker or retiree with a financial contribution towards the purchase of the health plan of their choice.

Even more important, and unlike Medicare, the FEHBP does not attempt to constrain costs by controlling prices and specifying services. Instead it sets only very broad guidelines over how plans must be structured and marketed, and specifies only a brief set of core benefits, permitting federal workers and retirees to choose the plan and benefits that are right for them. Cost restraint is achieved not with an army of Medicare-style price controllers, but through the operation of consumer choice in a market of competing plans.

Choices for Federal Retirees. The FEHBP system is open to all congressional and federal retirees who retired after July 1, 1960. Under current rules, a congressional or federal retiree is eligible to enroll in an FEHBP plan if they retired on an annuity with at least five years of continuous service at the time of retirement, or if they retired on a Civil Service disability. A federal or congressional retiree can assure coverage for spouses if they elect such survivor benefits for their spouses. And any survivor annuitant can even request FEHBP coverage for grandchildren, under certain conditions on or after August 11, 1994.[7]

Significantly, while private sector firms in recent years have been cutting back, or even eliminating private health insurance for their retirees altogether, the FEHBP has improved its coverage. Moreover, while the number of active employees has remained fairly constant over the past ten years, the number of retirees has grown, from 1.3 million to 1.6 million.[8] Congressional and federal retirees and their dependents now make up 40 percent of the total enrollment in the program.[9] And for these fortunate congressional and federal retirees, the FEHBP offers choices and services denied to Americans enrolled in the Medicare program. Among the features of the FEHBP:

* **Wide Choice of Health Plans**. No group of Americans enjoys the same range of personal choice over health plans as do active and retired congressional and federal employees. Their private plans range from fee-for-service to managed care plans. They can even obtain plans through organizations they trust. Plans sponsored by federal unions and employee organizations are particularly popular among federal workers and retirees -- almost one-third are enrolled in such plans. In recent years, managed care plans have

[7] Whether or not a child will be added to a family plan of a survivor is dependent upon the family status: "The deciding factor now is whether or not the grandchild would have qualified as a family member if the retired employee were still alive." See NARFE, p. 28.

[8] Carolyn Pemberton and Deborah Holmes, eds., EBRI Databook on Employee Benefits, (Washington D.C.: The Employee Benefit Research Institute, 1995), p.278.

[9] Ibid.

become quite popular in the FEHBP. But among the managed care plans, there are a variety of different types of options. There are Health Maintenance Organizations (or HMOs), including staff model HMOs, where physicians are paid on the basis of a salary rather than a fee. But there are also "group model" HMO's, where the HMO "rents" the services of physicians; "network model" HMOs, where the insurance company contracts with physician group practices; and "Independent Practice Associations"(IPAs), where the HMO contracts with individual doctors in private practice and groups of physicians at a negotiated rate. There are also "point of service" plans, where retired federal and congressional workers can choose to use a personal physician outside the HMO network for a higher copayment.

The FEHBP is very popular among federal retirees. Indeed, it is so popular that many federal retirees who qualify for Medicare decide instead to remain in the FEHBP. And as the National Association of Retired Federal Employees states, in its 1995 guide to federal health plans for retirees, "All FEHBP plans are good.... You can't make a serious mistake in choosing a FEHBP plan unless you choose a high cost plan or option when you don't need one." [10]

* **Choice of Health Benefits**. Federal retirees do not merely have a choice of plan. Unlike virtually all other Americans, active or retired, congressional and federal retirees also have the freedom to choose the services they want. Unlike Americans enrolled in the Medicare program, congressional and federal retirees are not locked into a single, government standardized benefits package. Beyond the normal range of typical hospitalization and physicians services, congressional and federal retirees can pick from a variety of plans that cover such items as skilled nursing care and home health care by a nurse, dental care, outpatient mental benefits, routine physical examinations, durable medical equipment and prostheses, hospice care, chemotherapy, radiation , physical and rehabilitative therapy, prescription drugs, mail order drugs, diabetic supplies, treatments for alcoholism or drug abuse, acupuncture and chiropractic services. And FEHBP plans include catastrophic coverage -- in sharp contrast to Medicare.

* **Choice of Price**. Unlike the limited or non-existent choices of workers and retirees in the private sector, and unlike the rigidly controlled pricing in the Medicare system, congressional and federal employees have a wide range of options in terms of what they will pay in premiums, coinsurance or copayments. Under the FEHBP's financing formula, the federal government will contribute up to 75 percent of the cost of a plan up to a maximum dollar amount (currently $1,600 for individuals and $3,490 for families).

If congressional and federal retirees wish to choose a very expensive "cadillac" plan, with a rich set of benefits, they may do so, but they make the decision to pay extra . If, on the other hand, a retiree picks a less expensive plan, he or she saves money on their portion of the premium. Private health plans compete directly for these consumers' dollars.

Needless to say, the dynamics of a competitive market in the FEHBP have had a positive impact on premium prices for federal employees and retirees. According to the Congressional Budget Office (CBO):

> Over the past five years, FEHBP plan premiums have increased an average of 6.8 percent a year, whereas the premiums paid by medium and large firms surveyed by Hay/Huggins Company, a benefits consulting firm, increased by 10.8 percent a year. Furthermore, FEHBP premiums are expected to decline by 3.3 percent in 1995; the Congressional Budget Office projects, however, that aggregate private health premiums are likely to rise by about 5 percent.[11]

According to the CBO, Medicare hospitalization (HI) costs will rise at a nominal rate of 8.4 percent per annum between 1995 and 2000, and the Medicare supplemental medical insurance (SMI) plan costs will rise at a "nominal rate" of 12.9 percent between 1995 and 2000.[12]

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[10] See Federal Health Benefits Information and Open Season Guide, 1995, The National Association Retired Federal Employees (Washington D.C., 1994), p. 11.
[11] Congressional Budget Office, Reducing the Deficit:Spending and Revenue Options, A Report to the Senate and House Committees on The Budget, (February 1995), p. 184.
[12] Ibid.,p.225.

Many federal retirees, but not all, have access to Medicare system, as well as their FEHBP plans. For retirees who retired from the federal government during or after 1983, and met Social Security earnings criteria, are eligible for Medicare's hospitalization program. All federal workers are eligible for Part B at age 65, whether or not they ever worked under the Social Security system. Whether it makes sense to enroll in the Medicare Part B is dependent upon one's personal needs and choice of FEHBP health plan. Retirees are given advice on these issues by consumer organizations such as the National Association of Retired Federal Employees (NARFE). Washington's Consumer Checkbook, a consumer organization, gives retirees advice on the best options, such as enrolling in plans that coordinate with Medicare. Various other groups rate plans and provide information on plan services, quality, and levels of benefits.

Deficiencies in the FEHBP The FEHBP is not without deficiencies. The most significant is that plans must offer community-rated premiums, meaning they must offer a plan to healthy 19 year-old at exactly the same premium as they charge a very sick 89 year-old. This inevitably leads to the problem of adverse selection. Still, the FEHBP functions so well that even this problem does not undermine the program. Nevertheless, it does introduce distortions and perverse incentives that prevent the FEHBP from functioning as effectively as it should. A wise reform would be to vary the degree of assistance to FEHBP enrollees at least according o their age and to permit plans to vary premiums also by age. That would allow plans to compete more effectively and to offer services with less vulnerability to adverse selection.

A REFORM AGENDA FOR MEDICARE

Congress has committed itself to curbing the growth of Medicare spending in order to restore the financial stability of the program and thus prevent out-of-control Medicare spending from swallowing up money for other programs or forcing huge increases in taxes. To carry out this wise commitment, Congress can proceed in two ways. It can, as it has done in the past, impose tighter regulation, stricter price controls and cut medical services for the elderly. But experience shows that strategy yields only short-term spending reductions at best. In the long run it does nothing to curb runaway spending, and yet undermines the quality of care for the elderly.

The other option for Congress is to achieve spending restraint by giving the elderly greater control over their Medicare dollars and greater opportunity to use their dollars to select the health care plan and services that are right for them. Such a reform, modeled after the health system serving federal retirees, would use consumer choice and competition to curb waste and improve care.

Such a reform would include three principles:

Principle 1: Medicare should be changed from a defined benefit program into a defined contribution program.

Principle 2: The elderly should be allowed to use their Medicare dollars to enroll in a plan with health services that they choose, not services that bureaucrats or politicians have chosen for them.

Principle 3: Cost control should be achieved through consumer choice and competition, not central planning and price controls. Indeed, HCFA's complex system of price control and other restrictions should be phased out.

A reform incorporating these principles would be to provide Americans eligible for Medicare with a voucher to purchase the Medicare plan of their choice. The amount

of the voucher would be the combination of two amounts, reflecting the financing of today's Part A and a reformed Part B. The two elements of the voucher would be:

Portion (A) Part of the voucher would be an amount, adjusted by age, sex and geography, intended to cover the actuarial equivalent of the hospital and other services in today's Part A of Medicare. This portion would not be means-tested.

Portion (B) The other part of the voucher would be based on an amount, adjusted by age, sex and geography, intended to cover the actuarial equivalent of the services currently in Part B. This base amount would be means-tested to determine the dollar amount of this element. And since today's Part B is voluntary, the elderly would be able to decline this portion of the voucher.

An alternative form of defined contribution, rather than a voucher, would be for the Medicare program to cover a certain percentage of the premium for the plan of the elderly's choice, with a maximum dollar amount of contribution. This structure of contribution would be more like the FEHBP, but would mean somewhat less financial assistance for lower-income elderly.

The elderly would be able to use the voucher (or the percentage contribution) to purchase a Medicare approved health plan of their choice. Medicare would distribute information on the plans to the elderly, as well as a checklist to permit the elderly to pick their desired plan. Medicare would then inform the appropriate plan of the retiree's choice.

These plans, somewhat like plans offered through the FEHBP to retired federal workers, would have to meet certain basic requirements to be marketed as Medicare-approved plans:

Plan Requirement #1 The plan would have to meet certain basic financial requirements to assure their financial strength.

Plan Requirement #2 The plan would have to specify its services and costs in a standardized manner, to enable the elderly to choose without confusion.

Plan Requirement #3 Each plan would have to offer coverage designed to be actuarially equivalent to Part A (for those declining the "Part B" portion of the voucher) and a plan with additional services equivalent to the services in Part B (for those who wanted the full voucher).

Plan Requirement #4 Each plan would have to contain a core set of benefits, including catastrophic overage. This core would be leaner than Medicare today, thereby permitting the elderly to purchase a less expensive basic plan and supplement it with other optional services, or — with the help of the voucher — buy those services directly from providers. As an option, plans could offer a Medisave option, allowing the enrollee to pay directly for services out of an account, with insurance only for catastrophic expenditures. The core benefits for those declining the "Part B" portion of the voucher would be less extensive, and focused on hospital services. If a senior declined the "Part B" portion of the voucher they could buy additional insurance or pay for benefits without any requirement that these additional services comply with any federal guidelines. Thus, just as today, the equivalent of part B coverage would not be compulsory.

An alternative would be for Congress to require that, at a minimum, each plan must contain at least the specific services available today under Medicare, yet allow plans to offer additional services — with perhaps higher copayments for services currently in the Medicare package.

Plan Requirement #5 Each plan would have to set its premiums according to limited underwriting principles. These would be age, sex, and geography, but not health status. One exception to this general underwriting limitation would be to permit "lifestyle" premium discounts for seniors willing to enroll in sickness prevention and health promotion programs.

A reform based on this consumer-choice approach would have numerous advantages for the elderly and the taxpayer.

Personal Freedom. Under a consumer choice system in Medicare, elderly Americans could choose the type of private health insurance that best meets their individual needs. With the advice and counsel of their doctors, they would be able to pick not only the level of benefits above a basic set of hospital and physicians services, but also a broad range of medical services and treatments that are available on the free market. Consulting with their doctors, rather than waiting for approval from the bureaucrats at HCFA, this means that the elderly would be able to take immediate advantage of changes in treatments, medical procedures, and service delivery innovations. The only large group of the elderly with access to similar breakthroughs today are retired Members of Congress and federal employees.

Value for Money. Like retired federal and congressional retirees, Medicare beneficiaries would be able to pocket any savings from their personal decisions. While the cost of health care for the elderly is considerably higher than the cost of health care for active workers and their families, the level of the government contribution to their health plans would also be higher, depending on differences in age, sex, and geography.[13]

Controlling Costs. While by no means a perfect market, the FEHBP, serving retired Members of Congress and federal workers, has been able to control costs better than either private, employer based insurance or the current the Medicare program. According to the Congressional Budget Office and such private econometric firms as Lewin-VHI, this success is in large part due to the ability of Members of Congress and other federal workers, families, and retirees to comparison shop among the various health plans in their geographic region for the best value for their money. In recent years, even though the FEHBP enrolls approximately 1.6 million higher-cost retirees and dependents and includes progressively higher benefits, the FEHBP's outlays have increased at a much slower rate than the Medicare program.[14] With the establishment of a Medi-Choice system, similar in structure to the current FEHBP, the powerful market forces of consumer choice and competition should produce similar dynamics and thus similar results in the Medicare program.

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[13] As noted earlier, one central weakness of the FEHBP is that its insurance underwriting practices are outdated. It is currently a crude form of community rating, where there is no distinction in premium payments for active and retired federal workers and their families. This current FEHBP arrangement also directly contributes to the persistent problem of "adverse selection" in the FEHBP. The problems could be largely eliminated by an adjustment in the FEHBP premium structure, resulting in simultaneously higher premiums for retirees than active workers, along with an increase in the government contribution to retirees chosen plans or a tax credit for federal retirees to offset the increased cost. For a discussion of how to improve the FEHBP, see Robert E. Moffit, "Consumer Choice in Health :Learning From The Federal Employees Health Benefits Program," op. cit. pp.17-19; see also Stuart M. Butler, "Reforming Health Insurance: Analyzing Objections To The Nickles-Stearns Bill," Heritage Foundation Issue Bulletin, No.193, June 14, 1994.

[14] Source: Office of Personnel Management, Office of Actuaries, Table entitled "Federal Employees Health Benefit Program, 1992 Contracts."

Reduced Red Tape and Bureaucracy. In administering a consumer choice system in Medicare, Congress could relieve the Health care Financing Administration(HCFA) of the task of trying to dictate the minutiae of virtually every facet of health care financing and delivery for the nation's elderly. Instead of administering complex and cumbersome system of economically inefficient price controls, or promulgating an seemingly endless stream of rules, regulations and guidelines, HCFA could simply transmit defined contributions, either in the form of vouchers or through electronic transmissions, to the plans of the elderly' citizens choice, certify private plans as meeting basic hospital and physicians benefits, meet fiscal solvency requirements, and guarantee catastrophic coverage (a benefit that Medicare does not now provide). Moreover, HCFA could promulgate and enforce serious rules protecting elderly citizens from fraud by insurance companies.

An AARP Health Plan? Much like the National Association of Retired Federal Employees (NARFE), which rates and grades the quality and benefits of plans offered to congressional and federal retirees, the American Association of Retired Persons (AARP), and other senior citizens organizations, could play a similar role in a revamped Medicare system, rating and approving competing plans on the basis of price, service, quality, and benefits for Medicare beneficiaries. In fact, there is every opportunity for the AARP, and other senior citizens organizations to sponsor and market their own health care plans, entering into competition with established insurance carriers, such as federal unions and employee organizations do today within the FEHBP.

CONCLUSION

Unless Congress soon takes action, the costs of the current Medicare program will continue to rise at unsustainable rates and will become insolvent. The Medicare program is structurally unsound. It provides a false sense of security for the nation's elderly population. Attempts at holding down annual cost increases of 11% per year through arbitrary price controls have failed. The Health Care Financing Administration (HCFA) has become an entrenched, intrusive and overly bureaucratic organization. It has issued volumes of rules, regulations and guidelines that are confusing not only to the public and lawmakers, but also to doctors, hospital administrators, and patients.

The new debate over Medicare reform is one of the most important domestic policy discussion since Congress debated comprehensive health care reform last year. Congress must make decisions affecting the lives of every American, working or retired, rich or poor, healthy or ill. It is imperative that participants in this debate, particularly Members of Congress, focus their attention on not only the financial health, but also the administrative structure, including the regulatory details ,of the Medicare system. While pursuing necessary spending restraints in Medicare and many other government programs in order to secure an end to these ruinous deficits, they must also remain open to the fundamental restructuring of the Medicare program with a view towards improving the quality, availability, and the security of health services to the elderly well into the next century. If Congress fails, then the elderly will be faced with a dramatic reduction in the quantity and the quality of their health care coverage, or already overburdened working families, now paying over one third of their total income in taxes, will be forced to pay record high levels of payroll taxes just to maintain the current level of benefits. Either consequence is tantamount to fiscal and political disaster. If Congress succeeds, and takes advantage of this historic opportunity to create a new Medicare system based on consumer choice and competition, it will not only be a great comfort to our nation's elderly , it will also serve future generations of taxpayers as well.

Chairman THOMAS. Mr. Kendall

STATEMENT OF DAVID B. KENDALL, SENIOR ANALYST FOR HEALTH POLICY, PROGRESSIVE POLICY INSTITUTE

Mr. KENDALL. Thank you. My name is Dave Kendall with the Progressive Policy Institute, which is the policy arm of the Democratic Leadership Council. I thank you for the opportunity to be here today.

Let me begin by recalling one of the lessons from last year's debate. The public cannot have confidence in a program that they don't know. That was the problem with President Clinton's health care alliances. They inspired little confidence in his plan because they would have been a brandnew institution in this country. And that is the danger of bold proposals like the ones we are considering today.

The Federal Employees Benefit Program, for instance, is a good model to be using to think about the reforms that we need to do, but most Medicare participants are not familiar with it. Instead, we need to build up from what we already have.

Medicare already offers vouchers. It is in the managed care program. And the growing popularity of managed care plans offers an opportunity to create fiscal discipline for Medicare that it has never had before.

HMOs are offering participants an alternative to rapidly rising costs, better benefits at lower prices. As a result, they are growing at an annual rate of 27 percent. The dark cloud raining on this parade is that taxpayers are not gaining much of the savings from the managed care movement.

The reason is simple. Medicare pays managed care plans 5 percent less than its fee-for-service costs. Even if we solved the risk adjustment problems, we would still be saving only 5 percent. So the public will never reap the full benefits of competition as long as Medicare benefits are tied to the fee-for-service costs.

The alternative is to base payments to managed care plans and, ultimately, to the government's fee-for-service plan on the best price in the marketplace. A competitive approach like this must be enacted step-by-step in order to win public confidence during the transition.

We recommend a three-part strategy: Test, verify and adapt. Test the competitive basis for paying managed care plans and any other kind of health plan; verify access to high-quality care at lower costs; and finally, adapt all of Medicare spending to limits set by competition. Let me explain in detail.

Testing competition means opening up Medicare's program to more than just HMOs. Other kinds of health care plans like PPOs and even fee-for-service private plans should be allowed to compete. A greater range of choices would make the option of joining a private plan more attractive to Medicare beneficiaries.

The government's contribution would be set initially near the average of all plans competing that way. Medicare participants would be assured that the government's contribution to their health plan would always be worth something.

The benefits offered by health plans should not exceed the cost of the current value of Medicare benefits. That would prevent the

competitive system from breaking the bank with extra benefits. But all plans would have to offer a core set of benefits, including prescription drugs. That is important, to make the private plans more attractive to older Americans and the disabled.

I think we could build in flexibility as we move forward in the system—as Dr. Butler indicated, by moving to high-deductible plans or medical savings accounts; but, initially, they are going to attract more healthy people. So if we have a problem today in risk selection in the managed care program, it will be even worse with the medical savings account approach.

The quality of care for each plan should be carefully assessed with hard data about the performance instead of simply relying on regulations to protect consumers. Medicare should follow the lead of large employers that write report cards on health plans for their employees.

I believe that consumers armed with good information are better regulators than bureaucrats wielding rules. Every Medicare participant should have a pamphlet that compares the cost, quality and services of each choice on the menu of plans, and including the current Medicare system. I agree with the sentiment of the Committee that we should be doing so much more in just providing better information to consumers.

The next step, verifying, means checking for savings as well as for high quality. Are the health plans saving money by risk-skimming the healthy? Are the plans more efficient because providers are doing more for less and not degrading quality? If Congress cannot answer these questions with confidence, then the pace of change should be slowed until it can. The final step is to adapt all of Medicare to a competitive system. As participation in private plans rises, more of Medicare spending will be set by competition rather than regulations. Medicare's fee-for-service plan should have the authority and flexibility to manage its costs as any other health care plan should. You can almost imagine a privatized HCFA. Confidence in the private health plans would allow Medicare to limit its spending increases to market conditions, and a fee-for-service spending cap would discipline Medicare's fee-for-service system without sacrificing access and quality.

In short, the pace of change in Medicare reform should depend on the ability of the government to win confidence in the new system.

The challenge of reform is summed up by what was said last year by a Medicare participant who was alarmed by the idea of having government-run health care. He said, keep the government out of Medicare. That is the sum of the problem we have today.

Keep in mind that the beneficiaries and the taxpayers have a common interest and that is fighting the high cost of health care. We need to forge a new relationship between the government and Medicare participants. The government must ask them to accept more responsibility for key decisions about the costs and quality of their health care and, in exchange, the government must make sure that they have the resources and the information to make the right decisions for themselves.

Thank you.

[The prepared statement follows:]

TESTIMONY OF DAVID B. KENDALL
PROGRESSIVE POLICY INSTITUTE

The growing popularity of managed care plans in Medicare has created the opportunity to achieve fiscal discipline. For too long, older Americans, the disabled, and taxpayers have had little choice but to pay Medicare's rapidly rising premiums and out-of-pocket expenses. Today, private health plans—namely, health maintenance organizations (HMOs)—offer Medicare participants another choice: better benefits at a lower price. But taxpayers are saving little because Medicare's government insurance plan, which is based on fee-for-service medicine, is shielded from competition.

Under current law, payments to managed care plans are tied to Medicare's less efficient fee-for-service plan. Instead, payments to all health plans—both private and government—should be based on the best price in the marketplace. To compete, Medicare's fee-for-service insurance plan should have new authority and flexibility to manage its costs. Such competition would unleash Medicare's buying power by transforming "beneficiaries" into responsible consumers. They would have more control and responsibility for Medicare spending, thereby lowering costs for taxpayers.

Competition offers an alternative to the price controls and spending limits preferred by many Democrats and the arbitrary budget caps proposed by Republicans. On the one hand, the regulatory approach has been largely exhausted. The controls that have been developed and refined over the last thirty years do not have the potential to restrain Medicare's rising costs to available revenue. On the other hand, the proposed budget caps would reduce spending without regard to the consequences. No one knows how much and how fast to reduce Medicare spending without sacrificing quality and access to health care.

A competitive approach must be enacted step-by-step in order to assure public confidence during the transition. First, a competitive basis for paying private health plans would be widely tested. Next, access to high quality care at lower costs would be verified. Finally, all of Medicare would be adapted to limits set by competition.

Medicare's "risk-contract" program, which pays managed care plans a fixed-sum for every person they enroll, is the logical place to start this new approach. It is the only existing opportunity for private health plans to assume the financial risk of managing the costs of Medicare patients. But it has many flaws that must be fixed before competition can be effective.

Flaws in the Current System

Risk contracts already permit a limited form of competition between private insurance plans and Medicare's fee-for-service insurance. HMOs compete by offering

participants better benefits at lower prices. They combine into one package the benefits offered through Medicare's fee-for-service plan and supplemental benefits such as prescription drugs and low out-of-pocket costs. Medicare participants would otherwise have to pay more for a separate "medigap" insurance policy to get the same benefits. HMO enrollment includes 9 percent of all Medicare participants and is growing at an annual rate of 27 percent.

But the current program is poorly designed to capture the efficiencies of the marketplace. Its problems stem from an outmoded, regulatory approach to health care delivery, which is at odds with the consumer-driven marketplace taking shape in the private sector.

Meager Savings. Rather than paying managed care plans based on competition, the risk-contract program uses a rigid financial formula tied to fee-for-service costs. Specifically, a managed care plan receives 95 percent of Medicare's current fee-for-service spending level for every person it signs up, even though the plan's real costs are usually much less. The government could keep more of these savings, but instead, it requires managed care plans to spend them on richer benefits for participants. This rule means that many older Americans receive free dental care, eye and ear exams, and foot care, which they ordinarily would pay for out of their own pocket.

Long-Term Limits on Competition. Medicare's fee-for-service system limits the capacity of managed care plans to drive efficiency gains in local markets. Consider the example of the Minneapolis-St. Paul market, where the dominance of managed care plans has fundamentally altered the behavior of all doctors. Specifically, doctors have learned to get the same results with fewer tests and procedures, and these lessons have been taken by fee-for-service doctors as well as those in managed care. Yet further competition has been constrained by the fee-for-service nature of Medicare, which guarantees a minimal income to both the managed care plans and the doctors. As a result, participation in Medicare's risk-contract program has declined, and managed care plans for Medicare participants are switching to a different reimbursement system that is based on fee-for-service charges. The drive toward efficiency has come to a halt.

A related problem is that managed care payments in adjacent counties can vary by as much as three-to-one. Moreover, counties seldom correspond to natural market areas. As a result, managed care plans are reluctant to do business in an area where they could lose money by having the misfortune to sign up more people from counties with the lower payment rates.

Risk-Skimming. Many critics have accused HMOs of saving money by attracting enrollees who are healthier than average. To the extent this is true, the fault lies not with HMOs but with those managing the program. Congress and the Administration have not taken full advantage of measures to prevent risk-skimming. For example, Mathematica Policy Research, Inc., which was hired by the government to examine risk-skimming, has recommended lowering payments to manage care plans with patients whose health

history indicates they are healthier on average than the general population. This recommendation has not yet been adopted, but should be.

Restricted Choice. Medicare rules prevent managed care plans from offering patients the option to see doctors outside their network. As a result, older Americans and the disabled must agree to see only the HMO's doctors when they enroll.

Ineffective Quality Assurance. Medicare has two quality assurance programs that are weak and outdated. First, federal inspectors review each managed care plan's operations periodically without ever measuring its results. Second, a managed care plan's business must be at least 50 percent non-Medicare, which is based on a crude assumption: if it's good enough for the private sector, it must be good enough for Medicare. In contrast, employers and state Medicaid agencies are demanding sophisticated measures of managed care's performance.

Inadequate Consumer Information. Medicare does not ensure that participants have access to reliable information comparing the costs, benefits, and services of HMOs.

Step-by-Step Reform

Many of the flaws in the risk-contracting program can be fixed immediately through the following actions: 1) Expand the choice of private health plans for Medicare participants to point-of-service plans and preferred provider organizations, which allow patients to go to doctors outside of a provider network; 2) Provide comparative information to all Medicare participants about their private sector options; 3) Pay managed care on a market-wide basis rather than a county basis; 4) Permit health plans to offer cash rebates in lieu of extra benefits; 5) Assure quality through health plan report cards and satisfaction surveys instead of outdated methods; and, 6) Give the Secretary of Health and Human Services the authority and responsibility to prevent risk-skimming.

But the more fundamental problem—the lack of competition—requires broader reform. As long as payments to managed care plans' are tied to the fee-for-service system, savings will be meager and payments unstable.

To create competition, Congress should follow the path blazed by large employers. They have been successfully fighting runaway costs while keeping workers satisfied. The key has been letting workers choose their own coverage from a menu of plans that compares costs, quality, and service. Workers choose more cost-effective plans such as managed care because they see value in it. When workers become comfortable taking responsibility for their own decisions, employers limit their health care contributions to the cost of a managed care plan. But they have kept options for workers who want more expensive benefits to pay more.

The experience of large employers suggests the following strategy for Medicare reform:

Phase One: Test the Use of a Competitive System. Medicare would create a menu of private health plans from which participants could voluntarily choose annually. Private health plans would offer a core set of benefits including some not already covered by Medicare such as prescription drugs and a limit on out-of-pocket costs. But the overall value of the benefits should not exceed the equivalent value under Medicare's fee-for-service plan. This approach would ensure that the competitive system would have appeal to potential participants without breaking the bank.

Private plans could not discriminate against the sick by charging them higher premiums, but they would be free to compete using managed care or any other innovative system. Over time, more flexible benefit design should be permitted as Medicare becomes more successful in preventing risk-skimming. In the short run, however, high deductible policies, for instance, might attract only the healthy.

The government's contribution would be set on a local basis near the average of health plan premiums. Those who chose a plan that cost more than the average would either pay the higher cost themselves, and those in lower-than-average plan would receive the difference in cash. Without such a rebate, plans would have no incentive to bid below the average.

Every Medicare participant would have information that compares the cost, quality, and services for each choice on a menu of plans including the current Medicare system. The advantages of the new system would become clear: lower out-of-pocket costs, better services, and high quality.

Converting the whole country to a competitive system all at once would be precipitous and impractical. Instead, legislation should allow a competitive system to be phased in starting with the markets that could benefit the most: mature managed care markets where competition has already hit the limits under the risk-contracting system in such areas as Minneapolis-St. Paul.

Another interim measure would be to limit the HMO payment rates for those plans in the non-competitive system to increases of 6 percent, which is more in line with private sector experience.

Finally, Medicare should encourage private purchasing groups to negotiate on behalf of large groups of Medicare participants. Competition is more likely to be effective if Medicare creates purchasing systems similar to large employers, which are the most effective purchasers in the private sector.

Phase Two: Verify Access to High Quality Care at Lower Costs. If private plans perform as expected, then satisfaction surveys and report cards on patient outcomes will

reveal high marks even as costs come down. If not, additional safeguards will be necessary. But rather than relying on anecdotal information to evaluate private health plans, seniors deserve hard data to determine if lower costs come from true efficiency gains and not from degrading quality.

Phase Three: Adapt Medicare's Overall Growth Rate to the Limits Set by Competition. As participation in the competitive system rises, more of Medicare's spending will be set by competition rather than regulations. Confidence in private health plans will allow Medicare to limit its spending increases to market conditions. This market-based spending cap would discipline Medicare's fee-for-service system without sacrificing quality and access to care.

Since Medicare will need several years to develop this market-based cap, Congress will have to resort to the same stopgap actions used in the past to delay bankruptcy in Medicare's hospital insurance trust fund: moderate provider cuts and more patient cost-sharing.

In general, this approach ensures that the government's contribution to the health insurance will be restrained to the level of essential services without shifting costs on to the private sector. The marketplace, not arbitrary government limits, will establish the price at which providers are willing to care for Medicare patients.

Conclusion

The pace of change in Medicare reform should depend on the government's ability to win public confidence in the new system. An example of the challenge before Congress is the words of one retiree during last year's debate. The campaign against "government-run" health care led him to demand that his congressman keep the government out of Medicare.

The Progressive Policy Institute urges Congress and the President to recognize that taxpayers and those who rely on Medicare have a common interest: fighting the high cost of health care. Republicans must forgo arbitrary budget caps that anticipate the savings from competition before it has even begun. Democrats must acknowledge that preserving Medicare will require fundamental Medicare reform.

The real political challenge is to reshape the relationship between the government and Medicare participants. The government must ask them to accept more responsibility for the key decisions about the cost and quality of their health care. In exchange, the government must commit to make sure they have the resources and information to make the right decisions for themselves.

Chairman THOMAS. Thank you very much.

I have been sitting here trying to refine the analogy, and I came to the conclusion the difference between ice cream and a sundae is the topping. They both have the ice cream. The sundae gets the topping, and what you are saying, Mr. Kendall, is that after you test various programs, running an average price on the innovative structures, you verify they are getting quality for price, you can actually come back to the folks who are getting the sundae and say, we will provide the ice cream with your fee-for-service cap, but since you can get what we consider to be a reasonable and quality product for that same amount, if you want the topping, you are going to have to pay for it.

Mr. KENDALL. That is exactly right. That is what large employers have done. They have spent a lot of time educating and demonstrating to their employees that these new systems can work, and that is what the government is going to have to do.

Chairman THOMAS. Well, thank you both for your testimony.

The gentleman from Louisiana.

Mr. MCCRERY. Thank you, Mr. Chairman, and thank both of you for your testimony.

Dr. Butler, your testimony seemed to be pretty much in keeping with Dr. Wilensky's suggestion of—I think it was a suggestion—to move toward a voucher system, basically figuring out what the government can afford, based on the financing mechanism we have in place now, to provide for a base structure and then allow the elderly to decide among a number of choices in the private sector. Whether we set it up as we do in the Federal Employee Health Benefit Plan or we just let the marketplace work and provide some information, it is still basically the same approach. And that seems to be the plan that we keep coming back to, and I happen to like that plan.

Mr. Kendall, you didn't really comment directly on that approach. You kind of talked around it, and it sounded like you were talking about something very similar, but I couldn't quite tell.

Would you comment directly on the voucher and capitation?

Mr. KENDALL. It is a difference more in style than in substance. We believe that going to a defined contribution is ultimately the right goal, but the danger is that you would set the voucher at an amount that wouldn't be worth anything, or be worth something less than what would be politically acceptable and what would be good for health care policy reasons and good for older Americans and the disabled. That is the real trick, how to make sure that, as we move into this new system, we continue our commitment to making sure that everyone has good health care without reducing our financial contribution to the point where individuals can't fulfill that.

Mr. BUTLER. May I just make a point that obviously there are going to be complex issues to setting a voucher amount and also there are variations. We are not necessarily talking about a simple, voucher idea. It could be a system like the FEHBP is.

But the problems with setting a voucher are certainly no greater and probably much less than the system where we are trying to set fees and prices for every single service, to work right throughout the country, to get us the right kinds of selections and so on. I

think setting a broad voucher amount is a much simpler task than trying to set prices throughout the current system.

Mr. MCCRERY. It seems to me we have created kind of a dual health care system—one private, one public—and we have duplicated a lot of mechanisms that were already in the private sector for monitoring everything that is going on and checking prices and fees and peer review and all of this stuff that the government tries to do, which costs a lot of money. The private sector already does—maybe in a different way—but they do it out of their own self-interest, and if we could somehow get rid of that government responsibility and all the costs associated with it and let the private sector do that, it seems to me we might be better off.

Mr. BUTLER. Even within the government sector, it is very instructive to compare, say, the way the FEHBP serves Federal retiree employees and the way Medicare serves other retirees in terms of the way it operates—the things that Gail Wilensky was mentioning regarding basic information that is available and routinely provided, if you happen to be an over-65-year-old Federal worker.

There are all kinds of arrangements made for the various competing plans to provide standardized information. You can go to places and have all the plans there offering their wares in an organized situation. All these things are available.

So it is not even necessarily whether the government is involved or not. It is the basic incentive and structure of the system itself. One program depends—which is Medicare—on the government making every decision about prices and services. The other involves the government setting broad guidelines and giving a defined contribution and allowing the normal methods of the market in the nonprofit sector, in terms of providing information, to then begin to operate.

Mr. KENDALL. If I could just add one point to that. I think it is easy to bash the current system because it is inefficient—and I am no fan of it. But it has provided one value, I think, among many, that needs to be stated; as a conservative businessman told me, the one thing Medicare has accomplished is defining a product in health care.

Before Medicare, there was no standardization of a product which is necessary to make a marketplace work; and albeit with a clumsy and awkward way of doing it, it has given that.

Now, we need to replace that product definition with a new product definition, but I think it is important to keep in mind that that product is still defined in many people's minds the old way as a very real thing, and we can't just get rid of it.

Mr. MCCRERY. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

The only concern I have in that discussion is, it is always easier to talk about it than to do it. When you talk about a defined contribution or a voucher—in essence, the AAPCC was an attempt to try to do that, and what we heard from the previous panel is, it has been a disaster, even within relatively close regions on a county basis.

So even if we went to the concept so that you would have a list of plans—we will test, we will verify, then we adapt, then we have

a list of plans that get the Medicare Good Housekeeping Seal of Approval in terms of the profile and the rest, and that the Medicare beneficiary has a debit card that is worth so much and we give them plenty of information as to which ones are 100 percent covered by the debit card and which ones are 90 percent or 80 percent, and they go ahead and do it, we still have the problem of the regionality aspect of the way in which health care is delivered and how much you get for your dollar to build in.

But I think what I am hearing you folks saying is that if we would move to that level of the problem, we will have gone a long, long way.

Mr. BUTLER. I believe so, and I totally agree with what you said. But I think, say—Mrs. Johnson's idea of saying, let's start looking at, say, a market test in the area rather than trying to microanalyze all the different things is certainly one element of the movement.

As I also said earlier, it seems to me it is much easier there—not that there is no difficulty—but it is much easier to set a broad amount in terms of a voucher in an area than to try and make decisions and try to make calculations when the recipient themselves, the beneficiary, is not motivated to make decisions on the basis of total cost. That is a crucial difference. If you see the total cost, then you have a strong incentive to look for the one that is the best value. Now, that is lacking under the current system, which is one reason why the AAPCC doesn't work too well.

Mr. KENDALL. I think the question you are asking is about regional variation. I think that is real important because fundamentally healthy markets are regional in nature. Kaiser in California is a very different animal from Kaiser in this area. We ought to rate it separately as far as its cost quality, and it should be judged that way too. So that is why you need a competitively bid system that does allow for regional competition in setting that voucher.

Chairman THOMAS. Let me thank the panel, and I will tell you, Mr. Kendall, although there may be some assumption that you are tied somewhat politically to one party, the ideas you have offered are very refreshing and, frankly, some distance from the President's health care plan. Had he listened to you folks in terms of putting together a plan, we would have had a lot more common ground to work from.

I want to thank you, and I frankly believe we will be back to both of you, not only for the specific plan structure as we move forward, but frankly for a larger problem, and that is of marketing whatever the product is that we get, given the climate and the political incentive to make political hay with this product.

If we are in agreement that we need to make change and that the change we agree on is a professionally accepted one, I am very concerned about the way in which the change is transmitted. I look forward to working with both of you in that area.

Mr. Kendall.

Mr. KENDALL. Don't sign me up for the Republican Party yet. I want to see the bottom line of the budget first.

Chairman THOMAS. I am not interested in signing you up to the Republican Party. I am interested in signing you up to a solution

to the Medicare problem, which, frankly, I think transcends partisan lines.

Mr. BUTLER. Which it should do, certainly.

Chairman THOMAS. Thank you very much. The Subcommittee stands in recess until, I think, 1 o'clock.

[Whereupon, at 12:05 p.m., the Subcommittee was recessed, to reconvene at 1 p.m. the same day.]

Chairman THOMAS. The Subcommittee will reconvene.

I want to thank the gentlemen from Arizona. Your testimony is important to us and your real world experience, which is the basis of your testimony, is important to us. This panel is Dr. Block from Phoenix, Arizona; Dr. Jacobs from Phoenix, Arizona; and Mr. Zucarelli from Tucson, Arizona.

I would tell you that any testimony that you have that is written will be made a part of the record, without objection, and you may begin to inform us in any way you see fit about your experience on HMOs and Medicare.

I guess we will start with Dr. Block and then move to Dr. Jacobs. Then to Mr. Zucarelli. Thank you very much.

STATEMENT OF MARTIN BLOCK, M.D., MEDICAL DIRECTOR, UTILIZATION MANAGEMENT AND GOVERNMENTAL PROGRAMS, CIGNA HEALTHCARE OF ARIZONA, INC., PHOENIX, ARIZONA

Dr. BLOCK. Thank you, Mr. Chairman.

My name is Martin Block and I am a physician employed by CIGNA HealthCare of Arizona in Phoenix. At CIGNA, I am the medical director of Utilization Management for the Staff Model and for the Independent Practitioner Association, as well as the medical director for Governmental Programs.

CIGNA is deeply committed to the Medicare managed care concept and believes that Medicare risk HMOs are the model for the future. In our experience, covering the Medicare population through managed care networks achieves three goals: Seniors receive richer benefits with fewer out-of-pocket costs than under traditional fee-for-service Medicare, Medicare beneficiaries express satisfaction with the quality of care they receive, and employers providing retiree coverage save time and money.

CIGNA ranks among the largest investor-owned managed care companies in the United States with 48,000 employees around the world, $86 billion in assets, and 1994 revenues exceeding $18 billion. CIGNA is a leading provider of managed medical and dental insurance with 3.3 million members in our HMOs nationwide.

In Arizona, CIGNA is one of the State's largest HMOs and provides medical services to more than 400,000 participants in Medicare, Medicaid, individual, and commercial programs. We have been providing health care services to Arizona seniors through prepaid health plans beginning in the seventies with our predecessor company, which became the State's first HMO. Today we are in two counties for our Medicare risk program and have approximately 24,000 Medicare beneficiaries.

In 1993, CIGNA HealthCare of Arizona converted from a Medicare cost contract, which we conceived in 1985, to a risk contract, in short, because our competitors were increasing market share by

offering risk contracts with benefits similar to ours but with lower premiums. More than 97 percent of our cost contract members transferred their enrollment to the risk product.

Our careful management of patient care maintains the quality of services for our Medicare population while reducing by half inpatient hospital days per thousand. We work closely with our hospital networks, which are capitated for inpatient services, including skilled nursing facilities, outpatient surgery, and home health services. We emphasize preventive care services, provide case management for complex patients, and carefully manage all inpatient admissions beginning early in a patient's clinical course.

By effectively managing utilization and expenses, we have been able to return a significant amount of the savings to our Medicare beneficiaries in the way of enhanced benefits that seniors really care about. For example, we offer richer benefits such as prescription drug benefits, routine eye and hearing examinations, and partial coverage for glasses and hearing appliances. One benefit that our members would like to have is a popular point-of-service plan but, under current Medicare regulations, it is virtually impossible for managed care plans to offer this option.

Our enrollees are assured of receiving high-quality care because CIGNA HealthCare of Arizona is subject to rigorous accreditation and quality control programs. The Federal Government, in contrast, has no similar quality control programs for its fee-for-service Medicare population.

Our Phoenix Staff Model Plan was granted a 3-year accreditation by the National Committee for Quality Assurance, a national standards board. We also are involved in cooperative efforts with other managed care plans to develop quality improvement processes and closely track patient complaints, Medicare appeals, and disenrollments with the goal of improving service.

A recent survey found that CIGNA Medicare HMO members felt that we were more patient-oriented and better anticipated their needs than traditional fee-for-service Medicare providers. During 1994, the voluntary disenrollment rate was less than 3 percent, and only 39 Medicare appeals were made to HCFA, a rate of 1.57 per thousand which is below industry norms.

In summary, Mr. Chairman, Medicare risk contracting is a win-win situation for everybody in Arizona. Acceptance by seniors of the HMO risk product is on the rise and would accelerate if certain structural and legislative barriers were removed. CIGNA is committed to a growing presence in the Medicare market and believes that seniors' choices should be expanded in the managed care environment.

Thank you very much.

[The prepared statement and attachments follow:]

TESTIMONY OF MARTIN BLOCK, M.D.
CIGNA HEALTHCARE OF ARIZONA

Thank you, Mr. Chairman. My name is Martin Block. I am a physician and am employed by CIGNA HealthCare of Arizona, Inc. in Phoenix. At CIGNA, I am the Medical Director of Utilization Management for the Staff Model and Independent Practice Association delivery systems, as well as the Medical Director of Governmental Programs. I am Board Certified in Internal Medicine, am a member of the American College of Physician Executives, and the Board of Directors of the Arizona Association of Managed Care Plans.

It is a pleasure to appear before you and your committee today to discuss the important issue of how we can deliver quality health care to our over-65 population while controlling costs. CIGNA is deeply committed to Medicare managed care and believes that Medicare-risk HMOs are the model for the future. In our experience, covering the Medicare population through managed care networks achieves three goals:

- Seniors receive richer benefits with fewer out-of-pocket costs than under traditional fee-for-service Medicare.
- Medicare beneficiaries express satisfaction with the quality of care.
- Employers providing retiree coverage save time and money with Medicare managed care.

I would first like to provide some background on our company, and then explain our success in serving the Medicare population of Arizona through our managed care programs.

BACKGROUND

CIGNA ranks among the largest investor-owned managed care companies in the United States, with 48,000 employees around the world, assets of more than $86 billion, and revenue exceeding $18 billion. CIGNA HealthCare has an extensive network of HMOs with 3.3 million members, as well as PPOs, and a nationwide managed dental care network. Additionally, we are a leading provider of managed medical and dental insurance.

CIGNA HealthCare of Arizona, Inc. is one of the state's largest HMOs, providing medical services to more than 419,000 participants. We provide coverage to Medicare and Medicaid beneficiaries, as well as individuals and commercial enrollees through a statewide network. Services are provided to Medicare enrollees through the CIGNA staff models and independently contracted providers.

In Arizona, CIGNA has a long and successful track record of providing health care services to seniors through capitated, prepaid health plans that goes back to the early 1970s. CIGNA HealthCare 's predecessor companies began providing prepaid medical care in 1972, and became the first HMO in the state of Arizona -- receiving its Federal qualification in August 1978. Today, CIGNA's efforts have evolved into a two-county Medicare-risk program with approximately 24,000 Medicare beneficiaries. By focusing on quality of care, customer service and cost effectiveness, CIGNA has been able to steadily increase its Medicare membership.

PARTICIPATION IN THE MEDICARE PROGRAM

Beginning in the mid-80s, CIGNA offered benefits to Medicare enrollees through a cost contract with the Health Care Financing Administration (HCFA). Membership peaked at approximately 22,000 in 1989. After eight years of the cost contract, however, membership began to erode due to our competitors ' offerings of risk contract products, which had competitive benefits and lower premiums. During that

eight year period, our monthly member premiums increased from $45 to $69.50 in an attempt to cover costs. However, competitor risk contract products with no premium were available. It became clear to us that seniors were attracted to the benefits of a managed care health plan, but found the expense of cost contracts prohibitive. Thus, the competitive market helped drive our decision to convert to a risk contract for Medicare in 1993 -- much as the market place has led the managed care transformation of privately funded health care.

THE MOVE TO RISK CONTRACTING

Our offering of a benefit plan under a risk contract in Arizona met with overwhelming acceptance. More than 97 percent of our cost contract members enrolled in the risk product. The average age of our Medicare membership at that time was nearly 78 years old, compared to approximately 74 years for the general Medicare population.

Originally, we offered one benefit plan option - - with a $20 monthly premium - - in our staff model facilities to individual members only. This was done, in part, for ease of administration and also to limit membership until we could determine whether we could successfully implement utilization management measures for our Medicare membership while maintaining quality. Our immediate and dramatic reduction in inpatient hospital days with the risk contract proved that our utilization management measures were successful. During our last year under the cost contract, inpatient hospital days per thousand members were approximately 2,200. After our first year in risk, days per thousand dropped to about 1,100, or nearly one-half the amount realized under the cost contract. These impressive utilization results, it should be noted, were achieved with an older population than on average, while maintaining quality of health care.

HOW WE SERVE SENIORS

The key to CIGNA's success in containing health care costs is close management of the patient 's care. This is achieved through "partnerships" we have developed with our two major hospital networks to effectively manage the Medicare risk population. The risk, as well as the potential rewards, are shared between the Health Plan and its hospital partners. The hospital systems are capitated for inpatient services including skilled nursing facilities (SNF), outpatient surgery, home health services and durable medical equipment. Risk bands have been established, based on the utilization of these components.

Additionally, through the wise use of medical resources, CIGNA is able to provide quality care at a more reasonable cost. All new Medicare beneficiaries choose or are assigned to a primary care physician who manages and coordinates their care, referring them, when needed, for specialty care or diagnostic procedures. And nurse practitioners play an important role in assuring that SNF patients get appropriate, quality medical care.

The Health Plan works hard to meet seniors ' needs in the most efficient way possible. We focus on our patients ' entire needs, not just their medical care. By offering a full continuum of care, we can begin making appropriate plans for patients ' discharge early in their clinical course. SNFs are located on the main campuses of the hospitals and are designed to accept more seriously ill patients than most other SNFs. Once patients are admitted, they are reviewed on a daily basis by utilization nursing staff who also begin the discharge planning process to ensure a smooth transition to the most appropriate level of care. The nurses work directly with the patients and their families to coordinate services.

The Health Plan also has an extensive Ambulatory Case Management program to support the ongoing needs of members. Early identification of potential cases is an important aspect of the program. Once members are in the program, the RN Case Managers, under the supervision of Health Plan physicians, are responsible for evaluating patients ' needs, coordinating care and community resources and monitoring patients ' health status. For example, a patient discharged with the diagnosis of congestive heart failure may have a home health nursing visit to ensure that they understand their medications and how to take them, to teach them how to

recognize signs and symptoms of recurrent heart failure, and to assess nutritional status and safety issues in the home environment. The case manager also stays in contact with the patient by telephone or by home visit to ensure continued compliance, offer family support, and make the patient aware of community resources. The Health Plan also uses nationally accepted guidelines in managing inpatient admissions and lengths of stay.

We are very pleased with the results to date. Inpatient hospital days are down, while skilled nursing and home health services utilization is up. When compared to a traditional fee-for-service Medicare population, readmissions within 30 days are lower and mortality rates are, similarly, lower. In summary, CIGNA has reduced inpatient utilization by partnering with its contracted hospitals, establishing financial incentives, emphasizing preventive services, providing case management for complex patients, and carefully managing all inpatient admissions. CIGNA's effective management system has resulted in high patient satisfaction and satisfactory financial performance.

From the patient 's perspective, there are a number of advantages to participating in a managed care environment. These include generous benefits and the ability of an integrated health system to continuously improve the quality of health care delivery. Let me comment briefly on these two advantages of Medicare managed care: benefits and quality.

BENEFITS

Medicare enrollees are very attracted to our benefit package. We offer richer benefits than are available under traditional Medicare coverage, particularly benefits that seniors care about. For instance, our plans provide important prescription drug benefits, and routine eye and hearing exams, with a nominal copayment charge. Partial coverage for glasses and hearing appliances also is included. None of these benefits are available under fee-for-service Medicare plans today.

By effectively managing utilization and expenses, we have been able to return a significant amount of the savings to our Medicare beneficiaries in the way of enhanced benefits. We provide several preventive services which helps avoid expenses related to costly illnesses. Preventive services include routine physical exams and immunizations. We also provide "Wellness" classes with exercises specifically designed for seniors.

Unlike fee-for-service Medicare, our benefit plans provide unlimited days of acute hospital care. We also admit patients directly to SNFs when appropriate -- foregoing the prior three-day hospital stay required for coverage in traditional Medicare. World-wide emergency coverage also is provided.

One of the enhanced benefits, which members would greatly appreciate, is a point-of-service plan. In these plans -- also known as open-ended HMOs -- patients can choose out-of-network providers at any time and still receive reimbursement, although with a higher copayment. Point-of-service plans, it should be noted, are one of the most popular benefit plans currently purchased by the under-65 population. Unfortunately, current Medicare regulations make it difficult, if not impossible, for managed care plans to offer a true point-of-service product.

(Attachment "A"provides a more detailed discussion of CIGNA Senior Coverage. And Attachment "B"provides a comparison of Medicare and coverage provided by CIGNA HealthCare for Seniors.)

QUALITY MANAGEMENT

In addition to the generous benefit package, enrollees in CIGNA HealthCare for Seniors receive another important advantage. They are the beneficiaries of rigorous accreditation and quality control programs, which ensure that they receive high quality care. In contrast, the federal government has no such quality management programs for its fee-for-service Medicare population.

CIGNA HealthCare of Arizona has been reviewed by the National Committee for Quality Assurance (NCQA). NCQA, an independent non-profit organization in Washington D.C., accredits and evaluates managed care plans across the country to ensure that the managed care industry maintains high professional standards. The Phoenix Staff Model (employed physician) plan was granted a three-year accreditation, the most favorable rating given to health plans by NCQA. Although NCQA does not specifically review a plan's Medicare performance, many of the reviewed categories impact both commercial and Medicare members alike. These include provider credentialing and recredentialing, review of the ambulatory medical record, monitoring of adverse outcomes and sentinel events, preventive health activities, outcome-focused improvement activities and utilization management.

While NCQA approval is important to us, its rating only reflects a single point in time. We at CIGNA, however, recognize that quality management is not a one-time occurrence, but, rather, it requires continuous self-assessment and ongoing improvements. Thus, we are actively engaged in several quality improvement efforts. In August of 1993, the managed care plans of Arizona (including CIGNA), the Health Services Advisory Group and the Arizona Peer Review Organization began to work cooperatively to move from a quality "assurance" focus (e.g. removing "bad apples") to a quality "improvement" focus. The goal was to improve overall performance. For example, the ambulatory medical record was reviewed for patients with diabetes, and certain quality indicators were agreed upon. Subsequent reviews will provide participating Medicare HMOs with feedback on how they are performing relative to benchmark. Arizona health plans also have collaborated on several patient-oriented publications, such as "Understanding Benign Prostatic Hyperplasia" and "Management of Localized Prostate Cancer".

Additionally, CIGNA aggressively tracks patient complaints and Medicare appeals through its Managed Care Service Center. We take patient complaints very seriously, and the information is used to improve our services. For example, we now more broadly define an out-of-area emergency to allow routine follow-up care, rather than require a beneficiary to return to the geographic service area. CIGNA also tracks the reasons why members choose to leave a plan and uses this information as the basis for additional improvements.

While member satisfaction is high, opportunities for improvement remain. Some improvements our membership has suggested include:

- A point-of-service option to allow access to specialists in the service area, which I discussed earlier.
- Coverage of routine care out of the service area (e.g. coverage for Medicare beneficiaries who live for nine months in the Sun Belt and who spend summers in their home state -- "snow birds").
- Transportation for routine medical services.
- Expanded physician network.
- Expanded hospital network

MEMBERSHIP GROWTH

Realizing that we could effectively manage utilization patterns of the Medicare population, we sought to increase membership. In June, 1993 we began offering the Medicare risk product to employer groups which provide retiree coverage. These employers have generally been pleased. The risk product allows employers to see significant cost savings and lower long-term accounting liabilities for their over-65 populations, while keeping administrative expenses to a minimum. Because the government is already paying the HMO for basic services, employers can offer a Medicare risk plan for as little as $30 per month per person.

CIGNA regularly conducts focus groups to determine the potential market for the Medicare Risk product, and to assess the needs and wants of Arizona seniors. Although many seniors are not eligible or interested in a Medicare HMO due to the nature of their retirement benefits, others are underinsured, even with the purchase of a supplemental product, and see a Medicare HMO as a way to obtain richer benefits with fewer out-of-pocket expenses. Promotional activities conducted by CIGNA include television advertisements, print media, and direct mail. In addition,

CIGNA conducts meetings at places where seniors congregate (restaurants, senior centers, etc.) as part of its marketing efforts.

Other efforts to increase membership include: the development of a $0 premium benefit plan effective January 1, 1994; the expansion of the product in March, 1994 to include a limited number of CIGNA IPA providers; and the expansion of the service area in April, 1994 to include greater Tucson.

As a result of these efforts, our membership has steadily increased to over 24,000 Medicare beneficiaries today. The average age of our enrollees has decreased to approximately 74 years.

MEMBER SATISFACTION

We have found our Medicare members to be very satisfied with the Health Plan. A survey conducted by one of CIGNA's hospital partners revealed that despite shorter hospital stays, Medicare members enrolled in the risk program were likely to be more satisfied with their hospital experience than were fee-for-service medicare beneficiaries. Specifically, the survey found that CIGNA Medicare HMO patients felt that CIGNA was more patient oriented (92 percent vs. 85 percent) and better anticipated patient needs (96 percent vs. 85 percent) than traditional Medicare providers. Voluntary termination rates have been low. During 1994, the voluntary disenrollment rate was less than 3 percent. The majority of disenrollments are for non-voluntary reasons such as members moving out of the service area and deaths. Also in 1994, we forwarded only 39 Medicare appeals to HCFA for resolution. This rate of 1.57 per 1,000 members is significantly below industry norms.

It is clear that acceptance of this product among seniors is on the rise. I would observe, however, that further use by the elderly of managed care for their health care needs would accelerate if structural and legislative barriers were removed. One of the factors that has kept health benefits for Americans affordable has been the efficiencies of group purchasing by employers through the workplace. At this point in time, however, the purchase of Medicare is a one-person-at-a-time retail sale and does not contain any of the current efficiencies of scale that much of the rest of our system has. At a minimum, it should be easier for employees to join risk contractors through their employers when they retire.

SUGGESTIONS TO HCFA

I would like to suggest two other ways, in which HCFA could assist Medicare contractors in improving services to beneficiaries and easing the administration of the contracts:

- Create a climate that encourages innovation. A case in point is self-referral options (SRO). The SRO benefit is being requested by beneficiaries, yet implementation has been virtually impossible due to HCFA reporting requirements, particularly for Federally qualified plans.

- Establish one HCFA office as the contact for plans with multiple sites. This would be more efficient for both HCFA and the plans. For example, CIGNA currently must request approval of marketing material from each different HCFA regional office in which it has a health plan wanting to use the material. This results in duplicated efforts and wasted HCFA resources, and places an unnecessary burden on plans to comply with differing interpretations of the regional offices.

SUMMARY

In summary, let me emphasize that Medicare risk contracting is a win-win situation for everybody in Arizona. Compared with traditional fee-for-service Medicare plans, seniors in Medicare-risk HMOs receive greater benefits with lower out-of-pocket costs, while enjoying quality care and service. Retirees no longer have to worry about claim forms or physician fees exceeding Medicare's "reasonable and customary" limit. Providers have learned a new way of doing business which involves using the most cost-effective level of care consistent with a member's medical needs. The

resulting elimination of unnecessary services and inpatient days of care allows CIGNA to provide enhanced benefits at a lower overall cost. The competitive Arizona marketplace has encouraged innovative approaches and resulted in better benefits for Medicare beneficiaries.

Looking to the future, we are committed to being a part of the improvement and transformation in the Medicare market and believe that seniors' choices should be expanded in the managed care environment. Medicare managed care, we're convinced, is quality care.

Attachment A

The primary differences between our two benefit plans are summarized below:

BENEFIT	CIGNA SENIOR COVERAGE	
	BASIC PLAN	PREMIUM PLAN
Premium	**$0**	**$20**
Outpatient Copays	**$10 per visit**	**$5 per visit**
Prescription Drug annual Maximum benefit	**$750**	**$2500**
Hospital Inpatient Copay	**$300 for non-plan hospital admission**	**no copay for non-plan hospital admission**
Lens/frame benefit (routine)	**Not Covered**	**$100 allowance**
Hearing Services - Exams - Hearing aid appliances	 **Not Covered** **Not Covered**	 **$5 per visit** **$100 credit** for each hearing aid unit per year
Routine Podiatry Services	**Not Covered**	**$5 per visit**

An optional dental plan is also available for those members who desire dental coverage.

Attachment B

Following is a summary of benefits we offer that exceed those provided by Medicare.

Medicare vs. CIGNA HealthCare for Seniors

BENEFIT	MEDICARE COVERAGE	CIGNA SENIOR COVERAGE	
		BASIC PLAN	PREMIUM PLAN
Premium	Part B Medicare premium required	**$0** Part B Medicare premium required	**$20** Part B Medicare premium required
Preventive Care - Routine physical examinations	Not covered	**You pay $10 per visit**	**You pay $5 per visit**
- Routine Immunizations	Not covered	**You pay nothing**	**You pay nothing**
- Wellness Classes	Not covered	**You pay nothing**	**You pay nothing**
Prescription Drugs	Not covered	**You pay $7** for each prescription or refill up to 30 day supply. Maximum annual benefit of $750 is based upon the average wholesale price of the drug.	**You pay $7** for each prescription or refill up to 30 day supply. Maximum annual benefit of $2500 is based upon the average wholesale price of the drug.
Hospital Inpatient Services - Semi-private room and board, misc. charges - General nursing care - Operating room - Lab and X-ray tests - Drugs and medical supplies - Special care unit - Blood transfusions - Rehabilitation services such as physical therapy, occupational therapy, and speech pathology	You must pay a deductible of $716 for your first 60 days; for the 61st through the 90th day of a benefit period, you pay a coinsurance of $179 a day. If you use lifetime reserve days (60 total), your coinsurance is $358 a day	**You pay nothing** when admitted to our plan hospitals. (You pay copayment of $300 for admission, *including emergency admission*, to any in-area or out-of-area hospital that is not a plan hospital.) Maximum annual fee towards hospitalization is $716.	**You pay nothing** when admitted to any hospital. (All non-emergency hospital admissions will be scheduled through your primary care physician at a plan hospital.)
Physician Services For Hospital or Skilled Nursing Center Care (Inpatient) - Physician services - Specialist services - Major/minor surgery	You pay $100 annual deductible plus 20% of Medicare approved charges and non-approved charges up to the limiting charge.	Physician services are covered under your hospital benefit. **You pay nothing** for inpatient physician charges.	Physician services are covered under your hospital benefit. **You pay nothing** for inpatient physician charges.
Vision Services - Routine eye exams (once per calendar year)	Not covered	**You pay $10**	**You pay $5 per visit**
- Lens/frame benefit (routine)	Not covered	**NOT COVERED**	**$100 allowance** towards purchase of one pair of eye glasses or contact lenses annually.
Hearing Services - Exams - Hearing aid appliances (care must be received in a CIGNA HealthCare Center	Not covered Not covered	**NOT COVERED** **NOT COVERED**	**You pay $5 per visit** **$100 credit** for each hearing aid unit per year.
Routine Podiatry Services	Not covered	**NOT COVERED**	**You pay $5 per visit**
Durable Medical Equipment (medically necessary per Medicare guidelines) - Equipment - Prosthetic devices - Therapeutic shoes (for diabetics)	You pay $100 annual deductible, plus 20% of Medicare approved charges up to the limiting charge.	**You pay nothing** when you use a CIGNA HealthCare contracting provider and when prescribed by a CIGNA HealthCare contracting physician for services covered by Medicare.	**You pay nothing** when you use a CIGNA HealthCare contracting provider and when prescribed by a CIGNA HealthCare contracting physician for services covered by Medicare.
Emergency Care - World-wide emergency coverage (that meets emergency criteria)	Not covered	**You pay $50** per visit to an emergency room. You pay $300 copayment per non-plan hospital admission. (Your $50 copayment is applied to hospital admission copayment. Maximum annual copayment is $716.)	**You pay $50** per visit to an emergency room. You pay nothing per hospital admission. (Your $50 copayment is waived upon hospital admission.)

Chairman THOMAS. Thank you, Dr. Block.
Dr. Jacobs.

STATEMENT OF RICHARD JACOBS, M.D. VICE PRESIDENT, HEALTH CARE DELIVERY, FHP HEALTH CARE, PHOENIX, ARIZONA

Dr. JACOBS. Mr. Chairman, Members of the Committee, good afternoon. My name is Richard Jacobs. I am a physician, board certified in internal medicine, and also the vice president of health care delivery with FHP Health Care in Arizona, which is a division of FHP International Corp.

I received my medical degree from St. Louis University in 1976, did a medical residency program, and I have practiced medicine in both the fee-for-service setting as well as in the managed care setting and am now a physician administrator with an MBA, so I am not an expert on national health care policy. But I would like to share with you my experience and observations in managing health care to a Medicare risk population for a successful plan in a highly competitive environment, and I hope that that will be of some value to you.

FHP has been around a long time, over 30 years. We started in Fountain Valley, California with a Staff Model and we were in on the ground floor with a Medicare risk contract. We were one of the demonstration projects early on and so we have been doing this a long time.

We have over 2.3 million Americans that we take care of in 20 States, the District of Columbia, and also in Guam. We came into the Phoenix area in 1985 and then finally into Tucson in 1989. And right now the Arizona—FHP Arizona has over 182,000 members in three counties: Maricopa County, Pinal County and also Pima County, and roughly half of our membership are in the Medicare risk contract.

Arizona is a little different in that we have what we call a mixed model. Our members can choose their care from a private physician in the community, a contracted provider, if you will, and we have over 1,500 of those. We also have 17 or 18 community hospitals that we are contracting with so there is a lot of overlap between our network and the care provided by physicians in the community for Medicare, Medicare patients.

We also have a Staff Model which is an owned and operated type of thing and we have primary care physicians employed to provide services in our Staff Model, and we get very tight control of the services and quality in the Staff Model environment. We are the second largest Medicare risk contractor in the Nation and, as I said, we were the first Medicare risk contractor in Arizona.

If I could digress from my written statement just briefly to give you an observation about what that was like to start up a managed care plan in a new area, it might be of some value to you.

In 1985, when we entered Arizona, there was really—there was no Medicare risk contract at all. We lost millions of dollars in the first year trying to get this thing going. Our bed days at that point really approximated Medicare's experience in bed days. Over 2,000. Our physician costs were twice what we anticipated. And it took us over a year to really get a handle on all of that, to train the

physician network on how to manage the care, to teach them how to use the community resources in a coordinated way for the benefit of our members, and to bring the bed days down to a level that is really successful.

Right now, in an open network, not in a Staff Model, not in a group model, but in an open contracted network, we are running bed days of around 1,000 to 1,200, averaging around 1,100, which is half of what Medicare is running nationwide and represents a significant improvement in cost savings.

We get paid 95 percent of what HCFA pays fee-for-service Medicare area, and we really feel that our estimate is we save the Federal Government about $60 million nationwide because of that. We think it makes a lot of sense to manage the care. Until managed care came around, those services were provided in an ad hoc way. There was no way to coordinate the services and to bring to bear in a coordinated fashion all of the various complex services, such as social services and so on to take care of patients with many different needs. That is what managed care brings to the table.

You are going to hear—you heard from Dr. Block and you will hear from Mr. Zucarelli. Many of the different programs and methodologies that we use, in my written statement, those are really summarized as well, but what I would like to emphasize is managed care intuitively makes a lot of sense. It makes sense to plan the care. It makes sense to coordinate the services, to monitor how well you are doing and to use a TQM approach to incrementally improve the care.

Finally, we have found the 50–50 rule to be a real impediment to marketing to more and more seniors and I just might give you an anecdote.

In my church where I attend, even though we have been in this marketplace since 1988 and FHP has been around since 1985, I constantly have seniors who come up to me and say, gee, we just never heard about your plan. We wish we would have known about it a lot earlier. And it is really, I think, time to get rid of 50–50 and take the wraps off, and we can really reach a lot of beneficiaries who want this but don't know about it.

Thank you very much.

[The prepared statement follows:]

TESTIMONY OF RICHARD JACOBS, M.D.
FHP HEALTH CARE OF ARIZONA

Mr. Chairman and members of the committee, good morning. My name is Richard Jacobs. I am a physician and Vice President of Health Care Delivery for FHP Health Care in Arizona, a division of FHP International Corporation.

After receiving my medical degree from St. Louis University in Missouri nearly 20 years ago, I have practiced medicine in the United States Navy, in private practice, and in an HMO setting. My specialty is Internal Medicine and I have seen the practice of medicine evolve over the years both as a physician and as a physician-administrator. I am proud to be associated with FHP, an organization that for the past 34 years has had the best interests of its patients in mind.

Who We Are

FHP Health Care today provides a wide range of health care services to over 2.3 million Americans in twenty states, the District of Columbia and Guam. Since our entrance into the Phoenix area in 1985 and into Tucson in 1989, we have grown to serve over 182,000 residents in Maricopa, Pima, and Pinal counties. Roughly half of our membership in Arizona is comprised of Medicare beneficiaries who have chosen to receive their care through an HMO.

FHP in Arizona is a "mixed model" HMO. Our members can choose between receiving care from an independent physician in the community or from a health care professional employed by FHP. We contract with nearly 1,500 independent physicians in the state. In addition, we employ our own physicians, dentists, optometrists, nurses, and ancillary staff who are located in our fourteen medical centers in Maricopa and Pima counties. I am proud to note that FHP in Arizona received one year accreditation from the National Committee for Quality Assurance (NCQA) for both types of care delivery -- through our contracted physicians and through our employed staff of health care professionals. We hope to receive full three year NCQA accreditation this year.

FHP Senior Plan

FHP is the second largest Medicare risk contractor in the nation with 370,000 Medicare beneficiaries among our members. FHP's health plan for Medicare beneficiaries is called Senior Plan. It's an important part of our diverse portfolio of products and services. As the first Medicare risk contractor in Arizona, we have a record of initiating and maintaining health plans for seniors.

Because the Health Care Financing Administration (HCFA) pays us 95 percent of what it would pay fee-for-service physicians and hospitals in a given geographic area, we estimate that the federal government saved approximately $60 million in 1992 on our Medicare patients, system-wide, alone. Our Medicare members also come out ahead because they

receive high quality, comprehensive health care, plus other benefits such as prescription drugs which regular Medicare beneficiaries must pay for. It has been estimated that FHP's extra benefits save each of our senior members about $1,200 a year in out-of-pocket costs. That comes to approximately $335 million a year for our senior members. When the individual savings are combined with the five percent government savings, we believe FHP -- company-wide -- helps eliminate almost $400 million a year in unnecessary health care costs. The Medicare risk contract program is a "win-win" proposition for all parties concerned.

The Arizona Marketplace

Between December 1992 and December 1993, commercial and senior enrollment in Arizona HMOs grew almost 11 percent -- from about 1,175,000 members in 1992 to 1,301,000 members in 1993. These numbers do not reflect the number of Medicaid beneficiaries who receive their care through Arizona's unique Medicaid managed care system, the Arizona Health Care Cost Containment System (AHCCCS). That could be the subject of another hearing like this one.

Tucson ranks 6th among the 54 largest metropolitan areas in the country for HMO market penetration -- Phoenix ranks 12th. Just over 39 percent of the Tucson population are members of HMOs. Approximately 29 percent of the Phoenix population are enrolled in an HMO.

Quality of Care in HMOs

There have been considerably more studies of HMO performance than of any other health benefit option. A comprehensive review of the literature published from 1980 to 1994 appeared in the May 18, 1994 **Journal of American Medical Association.** The study analyzed the findings of 16 studies comparing the quality of health care provided in HMOs with care provided to other populations in other settings.

It was determined that HMO quality of care results were better than or equal to results in fee-for-service plans on 14 of 17 quality of care measures. The study found that people cared for in HMOs consistently received more preventive care (such as breast, pelvic, rectal, and general physical exams) than people in fee-for-service plans. HMO members also received more health promotion counseling than members of fee-for-service plans.

How Does FHP Provide Quality Care?

In the 34 years that FHP has been providing managed health care services, one fact is continually reinforced: providing quality health care is the best way to keep costs down. Our health care professionals utilize a number of techniques, pioneered by health maintenance organizations, to coordinate the care of each member. Let me cite a few examples:

- We use computerized practice guidelines and national standards to determine whether surgery or certain tests are really necessary. Very few individual physicians have this information at their disposal.
- Physicians and nurses make daily hospital rounds to monitor the in-patient care our members receive.
- We encourage patients to become more involved in deciding their course of treatment. FHP is pioneering a unique computerized interactive video program which allows patients dealing with breast cancer or prostate cancer, for example, to learn about all the options available to them. The more informed patients are, the more cooperative and supportive they are in their treatment plan.
- We have found that six percent of our member population uses 60 percent of our health care resources. By identifying these high risk individuals, we can intervene earlier in their course of treatment, proactively manage their care, and reduce costs.
- We care enough about our members with limited or fixed incomes to help steer them to available community resources, like food stamps, social security, and long term care options.
- We sponsor annual flu immunization clinics that are open to FHP members and non-members alike. Last year, over 25,000 Arizonans received their flu shot from FHP. The goal is to reduce the incidence of flu-related illnesses and hospitalizations the next spring -- and it works.
- Finally, we have adopted a continuous quality improvement approach to the way we deliver care and service. We carefully examine areas for improvement and put together Quality Action Teams to reduce or eliminate nonconformity. For example, we significantly reduced the time that members subject to blood clots received the results of their anti-coagulant medication. Our team of pharmacists help these members learn more about possible interactions of Coumadin, with their diet, exercise plan, other drugs, and other diseases.

Customer Satisfaction

Are we doing a good job? Our members think so. We regularly survey our members about the health care they receive and encourage them to tell us about the good things we are doing and the things we could do better. Using the results of these surveys, we work with our physicians, health care providers, service representatives, and staff to develop new or improved plans and programs that respond directly to what our members tell us.

In our most recent patient satisfaction survey conducted earlier this year, medical services, indicators on appointment availability, accessibility and convenience, front office personnel, and pharmacy all were found to be "better than expected."

As a federally-qualified HMO, we must abide by the rules and regulations established by the HMO Act of 1973 and amendments. We are required to meet all statutory, regulatory, and policy requirements laid out for Medicare risk contractors. Every two years, the Health Care Financing Administration visits every Medicare risk contractor and formally audits almost every aspect of our business. HCFA carefully looks at how we are organized, our fiscal soundness, cost reporting, utilization management, incentive arrangements, the way we deliver care, quality assurance efforts, marketing activities, procedures for enrollment and disenrollment, processing claims, grievance procedures -- both internal and with Medicare, and our compliance with the Equal Employment Opportunity and Americans with Disabilities Acts.

Other regulatory bodies "looking over the shoulders" of HMOs in Arizona include the Joint Commission on Accreditation of Healthcare Organizations, the Occupational Safety and Health Administration, the Arizona physician oversight organization, the Arizona peer review organization, the Arizona Departments of Insurance and Health, and others.

Does Competition Work?

Each of the HMOs represented on this panel -- and the six other commercial HMOs in Arizona -- compete in the marketplace. But that does not mean competition is based solely on price. We are all striving to keep our current members and bring in new members by providing more value for their health care dollar. We all hope to increase value by adding new benefits, developing new or improved products and services, improving our customer service, streamlining administrative functions, or developing larger provider networks. This is all for the good of our membership and the public at large.

Through the Arizona Association of Managed Care Plans, we also come together to inform and educate the public, business community, state legislators, and our Congressional delegation on significant health care issues. Our goal is to foster a better understanding of HMOs and how they impact health care quality, accessibility, and cost.

Through The Arizona Partnership for Infant Immunization (TAPII), Arizona HMOs are leaders in the statewide effort to meet the President's goal of 90 percent immunization of Arizona two-year-olds by the year 2000. Three of the four subcommittees are chaired by HMO representatives. Many other HMO employees volunteer to serve on each of TAPII's committees. They do it because it not only makes good business and medical sense to immunize, but because they care.

Suggestions for Reform

FHP, of course, supports federal and state efforts to encourage citizens into managed care settings. There are several recommendations that we believe Congress should enact to help these efforts along:

- Require HCFA to implement a proactive program to educate Medicare beneficiaries about the Medicare coverage choices available in their area.
- Eliminate the 50/50 rule. This rule has outlived its usefulness. Other means now exist to measure and assure quality. In Arizona, there is substantial HMO competition for the relatively small commercial population. However, there are fewer HMO competitors for the Medicare population. The result is that the 50/50 rule has in many instances limited the ability of seniors to enroll with a risk contractor of their choice. Nationally, the 50/50 rule is an impediment to expansion of the risk contracting program. FHP is committed to the Medicare risk program. We would like to expand into new markets. Currently, to develop a sufficiently large commercial base to be a risk contractor takes significant time, or enormous resources must be spent to acquire an existing commercial HMO which is not a risk contractor. From our view, the quickest way to expand the number of beneficiaries choosing Medicare managed care options would be to eliminate the 50/50 rule.
- Expand health plan choices available to beneficiaries to include a point of service/self referral option, a preferred provider organization, and other managed care delivery methodologies. Plans offering a Medicare SRO should adhere to the same marketing and selection practices presently in place for the Medicare risk program. All plans should be held to the same quality and fiscal standards.
- Streamline the new application and plan expansion process by amending current Medicare contracting guidelines to allow entities to seek first time qualification for a Medicare risk contract under the terms of a Competitive Medical Plan (CMP). Federally qualified HMOs should be deemed to have met these standards. Plans with at least three years of Medicare contract experience would not be required to file full applications. For multi-state plans, there should be "national use and file" standards so that marketing materials can be approved for use nationally without subsequent review by HCFA regional offices. Private accreditation would be deemed approval of a plan's quality assurance and delivery system.
- Subject each Medicare risk contractor to an annual external independent review consistent with HCFA guidelines pertaining to the quality, timeliness, and accessibility of services Medicare beneficiaries are entitled to receive.

Closing

HMOs -- like FHP -- provide high quality care with more comprehensive benefits, more preventive services, and lower out-of-pocket expenses. Because of our focus on quality, administrative efficiencies, coordination of care, and purchasing power we are able to provide these services at a lower cost than the fee-for-service system. We encourage people to see their personal physician to catch small problems before they become major ones. Our members can choose from a wide variety of board certified personal physicians who meet high standards of professional training and medical practice. Based on our experience and numerous independent studies, our members like their care every bit as much and often more than people in old-style fee-for-service plans.

HMOs -- organizations comprised of people just like you and me -- have grown rapidly in Arizona and across the country because a need existed. The healthy competition that has evolved in Arizona can serve as an indicator of what states with low HMO penetration can look forward to. HMOs in Arizona have been working successfully -- in the marketplace and as an industry -- to solve many of the problems in our health care system that you and your counterparts at the state level are trying to address.

Thank you. I welcome any questions you may have.

Chairman THOMAS. Thank you.
Mr. Zucarelli.

STATEMENT OF PAUL A. ZUCARELLI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PARTNERS HEALTH PLAN OF ARIZONA, TUCSON, ARIZONA; AND SENIOR VICE PRESIDENT, MANAGED CARE, HEALTHPARTNERS OF SOUTHERN ARIZONA

Mr. ZUCARELLI. Thank you, Mr. Chairman, Members of the Committee. My name is Paul Zucarelli. I am the president and chief executive officer of PARTNERS Health Plan of Arizona and senior vice president of HealthPartners of Southern Arizona, an integrated health organization. The PARTNERS Health Plan is the largest health plan in the Tucson area with approximately 120,000 enrollees.

We introduced our Medicare risk product 2½ years ago and currently enjoy 13,000 customers in that product line, representing slightly over 10 percent of Tucson's Medicare population.

PARTNERS, as I said, is part of an integrated health organization which joins together both the health care delivery infrastructure and the financing mechanisms of health care. We have shared governance and ownership based upon the following members: The area's largest community hospital, a tertiary care facility; a medical group practice model with six health centers, an independent physician organization that comprises one-third of the area's physicians, and the health plans.

We are convinced that an integrated approach is the best way to continue to provide quality health care services as is demanded by the marketplace. And to contain costs, it is also simultaneously demanded.

Let me comment on our reputation for quality. A recent independent survey of decisionmakers in Tucson's managed care market ranked PARTNERS as the only major health plan to combine high rankings from employers for clinical outcomes, service outcomes, and limited cost increases. Our internal monitoring of customer satisfaction found that our senior members in the risk product were even more satisfied than our other members in general, scoring statistically higher than the mean for overall membership.

I would like to share with you some specifics relative to our customers in the Medicare risk product. We currently provide free transportation services to members who are unable to get to a hospital for outpatient visits or inpatient stays or to physicians' offices for appointments within a 10-mile radius of their home. This service provides an average of approximately 1,000 trips per month to the elderly, and 70 percent of our riders have reported that without this service, they would be missing or postponing health care, which would greatly increase the potential for adverse health outcomes and results and, therefore, increased health care costs.

Another innovative program that we have rolled out for the Medicare population is what we have called a Geriatric Evaluation and Management Program, affectionately known as GEM. I would like to share this briefly with you.

We have a team—the GEM team consists of a physician, pharmacologist, geriatric nurse practitioners, social workers, registered

dietitians, and administrative coordinators that perform intensive evaluations on Medicare beneficiaries and include histories and physicals, nutritional assessments, pharmacological assessment, functional fitness interviews, psychosocial interviews, evaluations of mental health and depression screening, and safety and health risk assessments of their actual home environment.

Let me tell you a brief story about what this has meant to two of our Medicare risk members who happen to be a couple. I will refer to them as Mr. and Mrs. A. Mr. and Mrs. A became progressively more worried about being able to stay together in their home. Mrs. A was 81, was becoming more dependent on help, and her 79-year-old husband feared they would be separated by a nursing home wall. Mrs. A has diabetes, hypertension, cancer, glaucoma, and a history of falls.

The GEM team was able to approach the patient in a multidisciplinary fashion and detect early stages of Parkinson's disease as well. This may not have been picked up in an ordinary routine office visit by the physician. The treatment plan was able to effectively coordinate the already complex mix of medications she was on so that her Parkinson's would be effectively managed, without detrimental effect on the management of her other health problems. In-home support was arranged for Mr. A through a group of care givers. Three months after this evaluation, Mr. A's progressive arthritis and vision changes resulted in a GEM evaluation for himself as well. Early stage Parkinson's was diagnosed and an increased fall danger was noted in a gait evaluation. Podiatric care was prescribed as a care for Mr. A.

In-home support is still being used by Mr. and Mrs. A. However, in the face of complex medical problems, they are still at home maximizing their quality of life together. In conclusion, innovative programs like these are the result of taking the HMO concept and moving it forward.

In Tucson, Arizona, managed care plans serve the needs of Medicare members with excellent results. With four Medicare HMOs operating in the Tucson marketplace, nearly 50 percent of Medicare beneficiaries have voluntarily opted out of traditional fee-for-service medicine and into one of the managed care plans.

I would suggest you might want to survey these people directly to assess their perceptions of the increases in service, convenience, quality, and economy which they are currently experiencing.

I also believe the integrated approach, which our HMO is a part of, is a giant step in the right direction to serve, and more directly connect the customer with providers of service of care, so true productivity and accountability is the result.

We believe we are uniquely positioned in our marketplace to significantly reduce costs and provide better quality care because of our shared vision of our elements, namely, managing our communities toward a better health and improved health status within a finite set of resources. We think we are proving it is a worthwhile effort.

I would encourage you to look for incentives to make more of this development possible rather than allowing creation of restrictions, intended or accidental, which may hinder our ability to build a healthier community. We urge you to expand managed care principles to the Medicare line.

Thank you.

[The prepared statement follows:]

Testimony of

Mr. Paul A. Zucarelli
President & CEO
PARTNERS Health Plan of Arizona
&
Senior Vice President for Managed Care
HealthPartners of Southern Arizona

My name is Paul Zucarelli. I am President and CEO of PARTNERS Health Plan of Arizona and Senior Vice President for Managed Care with HealthPartners of Southern Arizona, a community-based, integrated health organization. PARTNERS Health Plan provides a variety of managed care services for more than 120,000 members in the Tucson metropolitan area and in rural counties of southern Arizona.

The term "integrated health organization (IHO)" may be new to some, so I will briefly explain it in a moment, because an understanding of this evolving configuration of health organizations can be very important to understanding some of the advances we believe we are developing.

PARTNERS Health Plan

Allow me first to briefly introduce PARTNERS Health Plan of Arizona. PARTNERS has been providing managed care services in Arizona since 1986. We began as a cooperative effort whose principal parties were an organization of several hundred independent physicians in the Tucson area known as Southern Arizona Independent Physicians (SAIP) and TMCare, a community-owned, not-for-profit health care provider which owns and operates the area's largest hospital, Tucson Medical Center (TMC).

Following initial success in the commercial HMO marketplace and growth in our provider network, PARTNERS introduced a Medicare Risk Plan, known as Senior Choice, in 1992. Current membership in PARTNERS' senior plan is more than 13,000, which represents approximately 10 percent of the area's total Medicare membership.

We are a full-service managed care company with products for individuals, large and small groups, and point-of-service plans in place.

Like the growth of our commercial HMO options, our growth in Medicare risk membership has been steady throughout the time that we have offered this option. We believe that the reason for this is our constant attention to the needs of the patient.

Integrated Health Organization (IHO)

Many observers of the development of HMO's have, wisely, counseled that as we seek to shape a system which is more economically responsible, we must not reduce the importance of the patient or member and substitute the dollar as the center point of our efforts. We believe that as our IHO forms into a truly integrated system, which places the incentives of all service providers in alignment with what creates better health within the communities we serve, we do the maximum to enhance both better care and economic responsibility.

This IHO is **HealthPartners of Southern Arizona**, a not-for-profit, community-based organization. It joins together the following organizations:

Southern Arizona Independent Physicians, with more than 500 medical care providers, including both primary care and specialty physicians;

GHMA Medical Centers a primary care and multi-specialty group practice with five major clinics throughout the area and which is the physician group responsible for introducing managed care into southern Arizona some 20 years ago;

Tucson Medical Center a 615-bed hospital with a 50-year reputation for quality acute and tertiary care, and the other operating entities of TMCare including the area's leading behavioral health hospital;

PARTNERS Health Plan with its 120,000 managed care members; and,

Arizona Physicians, IPA, the largest participating plan in Arizona's managed care Medicaid program known as the Arizona Health Care Cost Containment System serving approximately 111,600 members (APIPA is a partnership with Samaritan Health Services of Phoenix).

The process of bringing together all these interests is complex and difficult. We are, nonetheless convinced that this is the best way to both continue to provide quality health services as is demanded by the marketplace *and* to contain costs as is also demanded. The community-based IHO brings providers of care (inpatient as well as outpatient, tertiary as well as primary) into the same organization and simultaneously finances the managed care products directly to the marketplace. All constituencies are thus linked daily to the member. We believe we are, indeed, achieving a real alignment of interests and incentives which includes payors, members and providers in a partnership which can truly minimize conflict and maximize health improvement results for our members.

We view ourselves as being in the business of managing the health status of the defined population we serve in our communities. Most HMO's are arrangers or coordinators of care through contracted networks; we, on the other hand, serve as an integral part of our communities (we are among the largest private employers in southern Arizona) and both provide care and finance it for the community.

We seek to create the best value for our customers and we understand "value" to be the optimal intersection of quality service with cost containment. By being *together* in our understanding of that mission, and in our rewards for success, we seek to remove the counterproductive wrangling that is often seen between provider and insurer or between hospital and physician. Inevitably, where such diversion is present, it is the patient who suffers. We are convinced that this new configuration of health services in a community-based IHO is capable of genuinely incorporating the customer at every level as a full partner to the benefit of the health status of the entire community.

The various organizations involved in HealthPartners have been working toward integration for two years and began to put integrated programs into place under the HealthPartners name this past November.

<u>HMO Quality for Medicare Enrollees</u>

The overall reputation of PARTNERS Health Plan has been built on providing high quality care while simultaneously being effective at limiting cost increases. A recent independent survey of decision-makers in Tucson's commercial managed care market ranked PARTNERS as the only major health plan to combine high ratings from employers for clinical outcomes and service as well as for limiting cost increases.

Our own internal monitoring of customer satisfaction provides an interesting extension of that data specifically as it applies to our Medicare membership. In January of this year we surveyed a representative sample of all our health plan members measuring responses in a dozen areas which are pivotal in establishing member satisfaction.

We found that *our senior members were the most satisfied of all our members.* In all twelve categories of measurement our senior members responded with scores statistically higher than the mean score for overall membership (which includes commercial HMO and Point Of Service plan members as well). In eleven of the twelve measures, our seniors were the group which gave us the highest scores and in the twelfth category, their high ranking was matched by those in one other category of membership.

Our measurement categories included such things as overall evaluation of care, access to specialty care, and time available with physician and their staff members. The survey was based on an instrument developed by the Group Health Association of America.

The strength of this expressed satisfaction in our services is perhaps best exemplified by our members telling us that they are very unlikely to switch to a different health plan, given the opportunity. When surveyed on this question (and while our overall membership response was very favorable) our members aged 65 and older were the *least* likely to express any inclination to change plans.

Extra Services for Seniors

Perhaps a part of the satisfaction our members express can be traced to some of the synergy of services which is available because of our integrated system.

TMC's hospital-based program of special services for seniors (which is available at no charge to our Medicare risk members) provides a free transportation service to members in need of inpatient or outpatient services at the hospital or to appointments at physician offices within a 10-mile radius for members unable to drive. The service provides an average of approximately 1,000 rides each month and 70 per cent of our riders report that, without this service, they would be missing or postponing medical services which would greatly increase the potential of adverse health results and increased health care costs.

This program also provides for significant discounts on classes at our FitCenter Plus, a center for exercise and wellness with a membership of more than 2,000 seniors. Staff members at FitCenter specialize in senior fitness programs and work in cooperation with members' physicians or restorative services providers. A recent 12-week study of warm water therapy demonstrated dramatic improvements in range of motion, shoulder strength and walking speed for participants. This takes place in a relatively low-cost setting which members find pleasant and productive. More than 50 classes per week are offered throughout the city at six different sites.

Our Medicare risk patients also receive free membership in another community-based program known as OASIS which offers a wide variety of classes and programs. Among them is an inter-generational tutoring program which matches trained senior volunteers with elementary school-age children with needs for assistance in reading and language skills who are not eligible for other literacy programs. Last year, 268 member volunteers provided more than 42,000 tutoring hours to 383 students from 37 schools throughout the area.

These are a few of the extra services and opportunities which come to Medicare members who chose our HMO; some are clearly and directly related to improving and maintaining their health and others work more indirectly. All are benefits which have been enthusiastically endorsed.

Innovations for Better Care

I'd like to tell you about two programs currently being piloted within the HealthPartners Network; they are of particular significance to Medicare members of PARTNERS Health Plan. These two programs literally bring together all the major components of the IHO, placing the patient's best interest at the center of the process, where it belongs. The programs are:

* a primary-care-based nurse case management system and

* an intensive geriatric evaluation and management system.

They are interrelated and complementary.

Our **primary-care-based case management,** just several months into its pilot process has already been expanded into seven physician offices from its original five. Available for our health plan patients of all ages, it tends to see predominantly a senior population. With this program we have a nurse case manager assigned to the office practice of participating physicians so that extended resources are available at the primary care level to identify and intervene in patients who are at risk for health difficulties.

Case managers work with patients identified by their primary care providers on the basis of diagnoses or risk factors. Patients with multiple diagnoses, frequent hospitalizations or multiple emergency room treatments are among those paid special attention.

The nurse case manager administers a health risk appraisal including a home environment assessment and works with the primary care physician in creating and implementing a plan of care. They identify and deal with gaps in support systems available to patients. It is an on-going process to give long-term additional support and reach to the primary care provider in bringing maximum results for each patient.

One simple example of the efficiency of this extra resource is the case of a woman who is now using night-time oxygen as a result of an extended, in-home evaluation by her nurse case manager. Because of the greater period of time available for evaluation within the case management system (compared to an office visit with only the physician) and because it can be in the member's home, a more complete picture of the patient's total health risks and needs can be gathered. In this case, an in-home visit determined that overnight oxygen monitoring was warranted, that in turn pointed to a risk from lower oxygen intake during sleep. A simple addition of night time oxygen is now working to prevent a more serious incident.

Our nurse case managers report a wide spectrum of experiences, some as simple as finding asthma patients at home with poor dust control, all of which leads to intervention and prevention at its most effective and efficient level.

The pilot study includes both independent physician practice and group physician practice settings. We are currently investigating extension of our case management system into other areas including pediatric care and working to make it more widely available.

The geriatric evaluation and management (GEM) program has been in operation for almost a full year, during which we have found substantial success in providing an unprecedented level of support for senior patients and for their primary care providers by carefully coordinating resources available within the various segments of our IHO's operating entities.

Primary care providers are offered the opportunity to refer Medicare risk patients whom they believe to need special attention into this program for evaluation. The GEM program consists of health professionals in numerous disciplines from each of our major IHO component areas: hospital, health plan and physician practice. This team (a pharmacologist, a physician, a geriatric nurse practitioner, a social worker, a registered dietitian and an administrative coordinator) performs a coordinated, intensive evaluation covering such areas as:

* history and physical
* nutritional assessment
* pharmacological assessment
* caregiver interview
* functional fitness interview
* psycho-social interview

* evaluation instruments for mental state and depression screening
* an safety and health risk assessment of their home environment
* and others.

Results and recommendations from the team's collaboration are returned to the primary care provider in an individualized plan for interventions and desired outcomes.

It's proving to be a very good system, but only to describe its intention and organization leaves the patient out of the center. Allow me to tell you about a what this has meant to some of our Medicare members.

Mr. and Mrs. A had become progressively more worried about being able to stay together and in their own home. Mrs. A, who is 81, was becoming more dependent on help and her 79-year-old husband feared they would soon be separated by nursing home walls. Mrs. A has diabetes, hypertension, cancer, glaucoma and a history of falls. Progressive weakness, renewed falling episodes and memory changes caused her physician to send her for a GEM evaluation.

Because this team of trained, interdisciplinary members of our staff is able to approach the patient from so many different perspectives in a coordinated fashion, information often comes together that would be unavailable to the primary care provider in a normal setting.

The team's results made it possible to diagnose Mrs. A's Parkinson's disease which had been masked by the rest of her complex condition. The treatment plan was able to effectively coordinate the already complex mix of medicines so that her Parkinson's is being effectively managed without detrimental effect on the management of her other health problems. In-home support was arranged and Mr. A was introduced to a support group for care-givers.

Three months later Mr. A's progressive arthritis and vision changes resulted in a GEM evaluation for him as well. Early-stage Parkinson's was diagnosed in him and is now being managed and an increased fall danger was noted in a gait evaluation. Podiatric care was provided as a preventive measure.

In-home support is still in use by Mr. and Mrs. A. The key is that, in the face of complex medical problems, they are still in their own home and maximizing the quality of life together.

Mrs. B, who is 80, has a different but also complex set of medical problems. She suffers from macular degeneration and is legally blind, she has gastric ulcers, has urinary incontinence; she was anemic and her depression was growing.

As a part of the in-home evaluation, our geriatric nurse practitioner discovered that she had been seeing several physicians and had stockpiled, and was taking, 14 different medications and using alcohol. It is not uncommon, as you may know, for older adults to get trapped into substance abuse in this fashion and they are unlikely to volunteer the information to any one of the physicians they might be seeing.

Mrs. B was admitted to a program at our psychiatric hospital to deal with her dependency and her care plan is progressing.

Finally I'd like to tell you about **Mrs. C**, 88, who chose to leave our Medicare risk enrollment.

She moved to Tucson reluctantly from her home in the northeast so that she could be cared in the home of her daughter here. Her falls and memory difficulties, vision problems and other conditions caused her to move. She wanted, most of all, to remain independent and in her own home.

After medical progress from a treatment plan developed by the GEM team, and with connections to community-based resources in her home town which were arranged by the GEM team, Mrs. C chose to leave Tucson and to use the community support available allowing her to live independently in her northeastern home for the best of all possible reasons -- because she could.

Conclusion

Innovative programs like these, which don't aim at merely reducing costs but rather rearrange systems and resources into a more efficient and more patient-centered configuration, are the result of taking the HMO concept and moving forward with it.

At the core of the HMO philosophy is the belief that a policy of using resources to keep the patient well and to intervene appropriately in the earliest detectable stages of illness, disease or disability provides (considering not just finances, but lives as well) the most economical approach to better health. I am convinced that is a valid and valuable starting point. In southern Arizona managed care plans are serving the health needs of the full spectrum of Medicare members with excellent results at low cost. With four Medicare HMO's operating in the Tucson market nearly 50 percent of Medicare beneficiaries have voluntarily opted out of traditional fee-for-service medicine and into one of the managed care plans. I would suggest you might want to survey these people directly to access their perceptions of the increases in service, convenience, quality and economy which they are experiencing.

We believe that the marketplace response to our managed care plans for Medicare enrollees is strong evidence that we have taken the fee-for-service setting and improved upon what it has to offer.

While there might be individual primary care providers in a fee-for-service setting who have comprehensive resources available to them comparable to our case management and GEM systems, I am unaware of them in our marketplace. It is the combined strength, skill and commitment of the components of our IHO which can create this kind of resource on a system-wide basis and make it available to a greater portion of the population.

HMO's, I think you can agree, have not been stagnant. I submit that HealthPartners of Southern Arizona is an example of how rapidly and effectively community-based health organizations can innovate and focus on its residents in a community fashion. We can do the right thing for our customers if we continue to streamline the process. I believe the IHO configuration into which our HMO has joined is a giant step in the right direction and serves to much more directly connect the customer with the providers of service and care so that true and productive accountability is the result.

I ask you to keep in mind, as you consider legislative alternatives, that this type of progress is possible only when we are able to operate without counterproductive restrictions and cumbersome barriers.

We believe the case is strong to show that we are, in fact, paving a new path to better patient care while building a more economical system of delivery. HMO's, as integral parts of IHO's, are uniquely positioned to reduce costs significantly and provide better quality care because of the shared IHO vision of our core business as managing our communities toward better health within a finite set of resources.

I ask that you recognize that not all HMO's are the same. Some of us are community-owned and community-focused, without the need to serve the financial demands of investors seeking a purely financial return. We are, at HealthPartners of Southern Arizona, community-based and driven by a shared commitment with and to our communities. Our ultimate return is a truly healthier community.

It is an exciting and challenging prospect to extend managed care principles through a system aimed first at improved health status of patients and improved community health. We think we're proving it's a worthwhile effort and I would encourage you to look for incentives to make more of this development possible rather than allowing creation of restrictions, intended or accidental, which will slow down our ability to build healthier communities and contribute to a stronger nation.

Thank you.

Chairman THOMAS. Thank you very much.

Mr. Christensen.

Mr. CHRISTENSEN. It sounds like, Mr. Zucarelli, you are almost taking on more of a hospice care in a way. You have got a lot of the same elements of what the hospice care providers give a person who is in their last 2 to 6 months of life and—except you have taken it down to the situation where a person just enters the retirement phase of their life, meaning you have got the care givers, you have got all kinds of—you have got a social worker here. How can you afford to do that as a private sector company?

Mr. ZUCARELLI. Basically, it is a complete shift in thinking, philosophically, how you manage a patient's care. HMOs realize that there is only a finite set of resources in the system and that we will go broke quite quickly if we keep fixing people.

The early assessment portion of a person's condition regardless of their age is critically important, and to the extent we can prevent a continuation of disease progression or management of resources and enhance a person's quality of life at the same time, if they are chronically ill, but the key is to prevent chronic illness. To the extent the aging process takes its normal course, certainly we have to provide the care, but I agree with my other colleagues.

We have seen, simply in the acute care setting, days per thousand, and I would agree with the figures that my colleagues shared of roughly 2,000 days per thousand of hospital use being cut significantly. We are approximately running 1,100 days as well in our Medicare Risk Program. There is a tremendous amount of dollar savings there that you can reapply to nutritionists, some in-home care givers, and so forth.

Just a general comment. All the time we pick up safety factors in the elderly's home, like lamps, cord lamps, dust if they are asthmatic, if their house isn't clean, really, really simple things can be done that don't cost a lot of money but can save some dollars in the health care equation.

Mr. CHRISTENSEN. What is the cost that you have seen in terms of transportation? What does that average out to be? Is that something that is being widely done by your HMO managed care system as well?

Dr. JACOBS. You know, many of the benefits that you are going to see here for the three plans are very, very similar and the reason for that is we are competing in a marketplace for the same constituency.

Mr. CHRISTENSEN. Competition.

Dr. JACOBS. Yes, it is competition, it really is. I think a better question is: How can you afford not to do a proactive case management approach? Because we have discovered at FHP that 6 percent of our members incur 60 percent of the costs. It makes a lot of—there is a lot of leverage there. It makes good business sense to spend your resources on that 6 percent and proactively manage their care in order to keep them out of trouble. I mean, better, high quality health care in the long run is the least expensive health care that you can provide.

It is true that there are anecdotes of needed care being withheld in HMOs from time to time. You will hear that. But the bottom line is that an HMO that does that is going to cost you more.

Mr. CHRISTENSEN. What about the theory that the gatekeeper under a managed care system is not going to refer out to the specialists under the current, say, bonus system where a gatekeeper is provided—a primary care physician is provided a bonus if he is able to contain the costs and not refer out, and some people have said that people aren't going to receive the type of attention that they need from the specialists?

Have you experienced any of that kind of lack of specialized care for your seniors?

Dr. BLOCK. I can take that question. I know that is a concern. We have checks and balances in terms of looking at underutilization, as well as looking at overutilization, and when we evaluate our physicians, we don't look only at their cost of care, but we also look at other dimensions, and I believe probably other plans do similar things.

We review their charts, we make sure people are getting the appropriate preventive services. We look at patient satisfaction. We actually survey their members to determine if they are satisfied. And with this type of competitive market, people do vote with their feet. I mean, the risk of not providing quality care in addition to incurring later costs by not providing preventive services is that people will leave your plan and go to other plans where they perceive the quality to be better.

Mr. ZUCARELLI. Just to add to that, HMOs typically do capitate, however it gets back to the alignment of incentives issue, and we are becoming much more sophisticated whereby sometimes the specialists even share in the risk pools associated with primary care and hospital usage, and funds are commingled. So it takes the customer out of the middle, because if you look at HMOs in the eighties, we were basically a discount medicine approach with strong policing mechanisms on the front end with authorizations, and so forth.

But I think we have evolved—mature managed care plans have evolved now to more customer focus and have incentives that are aligned between primary care and referral specialists, as well as sharing in the hospital usage of resources. I am sure we all do this; we credential the providers. So that is such a value-added service.

Mr. CHRISTENSEN. Do all three of your organizations advertise for that customer? How do you go about getting your customer into the system? I asked a similar question earlier today to the panelists and HCFA has no process in place to refer out to managed care programs.

How do you all go about it?

Dr. JACOBS. Well, we have general advertising, which is image-type advertising. We also have tactical advertising in the local marketplace, and our sales is a one-on-one sales. It is very expensive to do it that way. I might comment briefly on the comparisons with the cost of administering Medicare versus the SG&A costs for an HMO.

FHP is running about 8.4 percent of revenue for its SG&A costs but it is not an apples to oranges comparison. We also have sales costs which are considerable. Also, running the gauntlet of administrative regulatory costs is very high as well, but we try to—we have general community just advertising, image advertising, and

one-on-one sales effort, and word of mouth has been the most important way of attracting members.

I can't emphasize enough the importance of competition, and competition based on something more than just on price. We compete in benefits, we compete on service and network. We compete across a broad range of program attributes and competition based just on price is a real mistake.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you.

Following that line of argument a little bit, the point was made that—I think Dr. Block, without a point-of-service option because of the prohibition on the part of Medicare, you obviously are not able to market a product that would be as complete as your customers would like. That is primarily affecting you on the basis of a less attractive product, doing less than you could do, or do you lose people over that? How fundamental is that failure to be able to provide a point-of-service?

Dr. BLOCK. We have done——

Chairman THOMAS. Is it evolutionary? That is, more people now are more concerned about it than they were 3 years ago?

Dr. BLOCK. We have done focus groups and surveys, and what we have found is there are people that are fearful of joining an HMO and have a supplementary product or an indemnity product plus Medicare because they still want to be able to access that one doctor that they have had for 10 years, their eye doctor or their heart doctor. And when they know that they cannot access that doctor through the lock-in HMO, they are not willing to consider that as an option.

I think the commercial experience will say that one way that commercial HMOs and carriers have introduced the HMO concept has been to go with a point-of-service option as kind of an interim step so that people do have the ability to see that one or two doctors in their life who are very important to them and still have all the benefits of an HMO.

Chairman THOMAS. Dr. Jacobs, you are talking about the difficulty with the 50–50 rule, which is somewhat similar. You can't market the product the way you want to market it because of the prohibitions which like a lot of things we do in government, had a real good reason at one time to establish what folks I guess thought was a quality check but which clearly is a limitation to a certain extent, if you want to specialize in an area.

And then in response to Mr. Christensen, you talked about the kind of advertising that you do. Do you use focus group or question new enrollees as to how they found out about you? I know you mentioned several times it was by word of mouth. Is that what you find to be probably the primary reason folks looked you up?

Dr. JACOBS. Mr. Chairman, I don't have those statistics at my fingertips. I do know that word of mouth is very important to us, but I can't give you a percentage, what percentage of our leads come from word of mouth. It is a high percentage, though, and we are inhibited by 50–50 to a significant degree.

One other impact the 50–50 rule has on us is that we are unable to take on Medicaid patients because they count toward the 50–50, and I know that access in Arizona would like for us to participate.

Chairman THOMAS. Well, this is another area that we need to get into because, when you talk about Medicare, you wind up with a certain profile of patients talking about Medicaid. And when you talk about Medicaid with certain profile patients, you wind up talking about Medicare. And in Arizona, 100 percent of the folk are in managed care on Medicaid and you are moving into a managed care Medicare situation.

We did not talk about it with the first panel, but this is an anomaly that we have to focus on, and I would guess, given the profile of Arizona and managed care and the seniors there, that you are going to be one of the most heavily impacted areas.

Mr. Zucarelli, you mentioned this GEM, the geriatric evaluation management. You mentioned a couple. First, the wife was afforded the GEM Program, and then the husband. What triggers a geriatric evaluation? Have you got a profile, there are certain aspects?

Mr. ZUCARELLI. Right. We basically market the program through the primary care physician and it is really to catch at the earliest onset some of the chronically ill Medicare enrollees so that we can provide more resources to the physician. It is usually people with multiple conditions. I am not a physician so I won't speak to the clinical end.

Chairman THOMAS. For example, if you had a couple and both were enrolled and it was triggered on one, wouldn't you want to just do the other one for a profile, or do you wait for certain symptomatic aspects for a profile?

Mr. ZUCARELLI. It is based on the team's evaluation. This example happened to be a couple. But the primary care physician called into the GEM Program and said I need the team to evaluate Mrs. A. The concern was really—Mr. A, he was functioning well but he was concerned that they were going to put his wife in a nursing home. When his vision started failing and his arthritis progressed, we did a complete evaluation, we picked up his gait problem in his walk and gave him the podiatric services. But the fact is, we have kept them together.

One comment I would like to add, Mr. Chairman, concerns the point-of-service product. I view the marketplace as evolving, and one of the biggest fears Medicare beneficiaries have is this concern that they are going to lose their choice of physician. We have seen that on the regular HMO commercial side, and that is, people our age used to HMOs and health plans because our employers have migrated to them. We have a generational gap or barrier we have to deal with and I would suggest a point-of-service plan is a means to an end and a transitioning product.

Chairman THOMAS. Yes, there is no reason why we can't eliminate that barrier. That is obviously going to be one of the things we looked at.

Dr. Block, you mentioned, and I believe Dr. Jacobs mentioned, the comparison that when you began, it was a 2,000-hour bed relationship between the program and Medicare and you basically cut it in half. In terms of that kind of behavior, obviously you are probably measuring quality slightly differently than other folk who tend to measure quality by quantity.

Have you had any difficulties in either articulating or getting people to understand the way in which you measure quality within

your system? Because, clearly, a reduction like that would normally be seen as a reduction in quality by sheer reduction of hours.

How do you counter that?

Dr. BLOCK. I think one of the things we do, and I suspect the other plans do as well, is to have a large number of nurse case managers. We call them patient care coordinators. They work with physician advisors in any of our hospitals to immediately begin case management of inpatients so the patient is not surprised, and the expectation is set for approximately how long they are going to be in the hospital.

And we also work with the physician groups to try to set the expectations early. I agree with the other two panelists that this really does lead to real savings. I had the pleasure of attending a conference where Senator Rudman addressed the American College of Physician Executives and he was trying to explain why the Medicare Program was so expensive. He talked about a case where a person was in there for an infection of the inside of the heart and they were hospitalized for a total of 6 weeks for antibiotics. Then someone from the audience, this being a managed care meeting, raised their hand and said, "If they would have been with an HMO, they would have been in for 2 or 3 days and then home for 6 weeks." It turns out the Medicare Program doesn't cover the IV antibodies at home. We would do nothing but cover those antibiotics at home. So once again we have real savings.

Chairman THOMAS. Once again, it is an attempt to try to create a system and then force a fundamentally different approach into that system and we have failed to respond to it. Dr. Block, you mentioned something which intrigued me because this is one of the normal arguments against a managed care program in general and clearly for seniors.

Arizona probably has a relatively high percentage of mobile seniors. They tend to get around a lot and travel. And you mentioned that you have an emergency coverage portion of your program on a worldwide basis that if I left Arizona as part of your HMO coverage, is that true, that I can get emergency coverage?

Dr. BLOCK. We have emergency coverage and I think this is mandated by HCFA worldwide. The coverage outside of the service area for emergency or urgent situations is regulated.

Dr. JACOBS. It is a requirement for us to do that, yes.

Chairman THOMAS. Just curious.

Mr. CHRISTENSEN. Mr. Chairman, could I ask——

Chairman THOMAS. Go ahead.

Mr. CHRISTENSEN. Have you had any of your participants who were in a fee-for-service plan who had their doctor move into the managed care system and how did that transformation process go? Did the participant follow that doctor into one of your plans? Were services reduced? Were they increased?

Dr. JACOBS. Mr. Christensen, we have about 1,500 contracted providers and we have observed that a number of those patients do move to the Medicare risk contract to the plan and stay with their doctor.

Mr. CHRISTENSEN. Has anything changed for that Medicare recipient from the fee-for-service to managed care when they have been in a long relationship with that doctor? Have you seen any-

thing change? Have you seen any evidence that those recipients are not happy when they move from their fee-for-service to managed care with the same doctor?

Dr. JACOBS. No, we have not seen that trend, and in fact, we have seen a real—I think we have seen a real improvement in care quality. It does take a while for that physician to learn managed care. It is a different way of practicing medicine. But in terms of the patients, I think patient satisfaction goes up. That has been our experience in the surveys we have done.

Mr. ZUCARELLI. And the elderly certainly appreciate no filing of forms and the no confusing paperwork.

Chairman THOMAS. On that point, Dr. Jacobs, I think you mentioned that FHP was founded in Fountain Valley, which is in Orange County. Fountain Valley is one of those new towns created in a beanfield, in the sixties. You were on a sharp learning curve to understand what you needed to do. Then you mentioned dealing with doctors to understand in part the structure.

But do you believe that there is something you have learned which is transferable to other areas? Are there management skills? Is there a model that could be recreated, or does it tend to have to be shaped in terms of the area you are in? To what extent are the ideas that you have learned exportable to the other States that you now practice?

Dr. JACOBS. I think the methodologies that we use are highly transportable. The reason for that is, we are all using the same technologies that are available in medical science, meeting the same anatomical, physiological and medical needs. Those aren't differing from State to State and patient to patient, in the same regulatory environment with the same financial structure, and that is really what is driving the methodologies that we use.

What is very labor and time intensive, however, is training the physician and provider network in how to use these methodologies, managed care methodologies, because what Mr. Zucarelli talked about, what Dr. Block talked about, what is in my written testimony, is that managed care attempts to coordinate a number of complex technologies and individualize it and use it in a proactive way to meet the patient's needs up front, and you need to get the physician to cooperate with that because he or she writes the purchase orders, and that means that you—that as a medical director, we need to get out of the community and interact with them on a one-on-one basis, develop a relationship and build trust, and then use that trust as a platform to teach them managed care, and some come along, you know, gleefully and others don't and it just takes time.

Chairman THOMAS. Dr. Jacobs, you have been in the business for 10 years, 5 years in Arizona. Have you seen a different product coming out of our medical schools and residencies in the last 3 to 5 years?

Dr. JACOBS. No.

Chairman THOMAS. Do you think you could go a long way toward reshaping those programs to create a product that is a little more focused in terms of what you need?

Dr. JACOBS. Yes, I really think that the medical schools are way behind the times. It is time—I believe it is time they start offering

courses in managed care. If physicians understood managed care when they came out of medical schools, we could really expedite this whole process.

Chairman THOMAS. You think if we got more of the payment for the medical education in the hands of the students, that we could shape those trends a little faster?

Dr. JACOBS. I don't know, sir.

Chairman THOMAS. One quick question.

Dr. Block, in terms of the benefits that you offer, beyond the basic, and you went through a litany of a number of benefits, are you offering those, and this is a tough question so I appreciate it if you don't feel comfortable in answering it. Are you presenting those because you think you need to offer those to be competitive, understanding the price mechanism that we now have available to you, or are those things that you feel comfortably that you can add to fill up the gap between what it really costs you and the 95 percent that is being paid, and what would you do in terms of that benefit profile if you didn't have the fixed 95 percent? To what extent are the add-ons market driven or a function of adding to a fixed cost structure?

Dr. BLOCK. I think some of the add-ons are market driven, and I think that as we suggested, we all compete with each other and so part of it is market driven. I think part of it is that it makes good sense to provide those benefits because what you are providing could potentially avoid more expensive benefits down the line.

Chairman THOMAS. And you could do that given the funding mechanism? If we changed it to a more competitive funding mechanism, you would then probably not offer some of those?

Dr. BLOCK. It is a little hard to say exactly how that would work, but I would guess that we would have to balance the need to be competitive with the need to provide benefits that are above those that Medicare provides.

Chairman THOMAS. Would you look forward to that opportunity to produce a truly competitive market price?

Dr. BLOCK. I think we could compete very effectively in the marketplace.

Chairman THOMAS. Thank you very much. We could go on for a long time and I believe we will be revisiting Arizona as we did on the Medicaid solution. We are going to be revisiting Arizona on the Medicare solution. I want to thank you folks for your testimony very much.

The Subcommittee is adjourned.

[Whereupon, at 1:45 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

TESTIMONY OF CHIEF MASTER SERGEANT JAMES D. STATON, USAF (RET.) AIR FORCE SERGEANTS ASSOCIATION

Mr. Chairman and distinguished committee members, millions of senior citizens who are retired from the military, the majority of them enlisted (noncommissioned), are concerned about how Medicare reform will affect them. I am testifying on behalf of the Air Force Sergeants Association's 160,000-plus members. AFSA represents the millions of enlisted active duty and retired Air Force, Air National Guard and Air Force Reserve members, and their families. Many of our members have served their nation, have entered their retired years, and are now among those currently receiving care through the Medicare system. We appreciate this opportunity to again include AFSA's views in your deliberations.

As AFSA has testified to this committee before, we are well aware of the challenge faced by this committee in finding ways to control costs within the Medicare program. The overall costs and fees for service become especially significant for our members because enlisted military retirees are the lowest-paid military annuitants. As such, significant medical bills can be devastating for this group of retirees. On behalf of our members, I ask you to seriously consider a cost-saving option that would benefit enlisted retirees.

We urge the committee to support **Medicare subvention:** The transfer of funds from the Department of Health and Human Services (HHS) to reimburse the Department of Defense (DOD) for care received by Medicare-eligibles either in TRICARE or at Military Treatment Facilities (MTF) (on-base medical care facilities). The question is not spending HHS dollars versus DOD dollars; the real possibility is to save *taxpayer* dollars by the non-parochial transfer of funds. Two bills have been introduced in the House that provide for some form of subvention: H.R. 580, sponsored by Representative Joel Hefley, and H.R. 861, sponsored by Representative Randy Cunningham.

To put the need for subvention in proper context, consider that for years, military members were told at every re-enlistment that when they retired, they and their families would have free health care for life. Enlisted retirees, especially, considered this a part of their deferred compensation package. Over the years, that promise has been broken. At age 65, they are abruptly prohibited from formally participating in military health care programs altogether. This practice must end, not just because it is discriminatory, but also because it shatters already-broken promises.

The specific method for incorporating Medicare-eligible military retirees into a managed care system is by allowing them to enroll or remain in the TRICARE program after age 65. This three-part system, DOD's health care plan of the future, is currently available only to under-65 military retirees and their dependents, and active duty family members. TRICARE includes an HMO option, TRICARE Prime. Prime's enrollment fee and cost-shares also provide lower-cost care than traditional "fee-for-service" care associated with Medicare Part B insurance.

The lower pension income of enlisted military retirees and their survivors magnifies the issue of health care costs. The TRICARE program promises to offer enrollees much lower costs than current fee-for-service insurance programs. Additionally, military retirees would be allowed to stay in the MHSS for life, as they were promised when they served their nation. At the same time, costs for their care would be reduced.

Another advantage in cost-savings would be that HHS would spend fewer dollars for the care it buys at MTFs than it does from civilian providers. Savings on-base are derived through the military's "utilization management," which is preventive in nature. This system ensures that medical resources are used in the most efficient way possible, and care is coordinated so that more serious treatment problems are headed off, thereby holding down costs. Put another way, the right treatment is given in the right place at the right time. Also, the cost of physicians is significantly tempered by the military rank structure.

Finally, MTFs already have an infrastructure in place, so the basic care components are there. The results, when comparing MTFs to civilian providers, are savings in costs, overhead and mark-up fees.

However, on-base care opportunities are very limited for Medicare-eligibles. Whereas all military retirees are eligible to seek space-available care at MTFs, most are viewed differently after they are forced to transition from CHAMPUS (soon to be TRICARE) to Medicare. In practice, MTF commanders are facing smaller and smaller budgets, and our older members, particularly our Medicare-eligibles, are denied space-available care because of a lack of DOD treatment funds. AFSA feels that Medicare subvention would make on-base care more likely for our older retirees when there is space available and, at the same time, save program costs by reducing the level of Medicare expenditures for military retirees. In any event, the option of TRICARE enrollment should be open to these retirees.

DOD leaders have repeatedly supported subvention for Medicare-eligible retirees. Now is the time to make it happen.

Mr. Chairman, thank you again for the opportunity to express our ideas on ways to lower the costs associated with the Medicare system. As you are deliberating this issue, we urge you to give serious consideration to AFSA's ideas on the matter. Approving ways to keep all retirees in the military health system is not only cost-effective, it also keeps a promise made to retirees, i.e., that they would have lifetime, affordable care as part of the military family.

The men and women of the Air Force Sergeants Association wish you well as you work to accomplish your important mission. As always, we are available to assist you in matters of mutual concern.

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Medicare HMO Enrollment Growth and Payment Policies Hearing

Written Testimony for the Record
Submitted by the
American Academy of Actuaries'
Medicare Work Group

June 8, 1995

The American Academy of Actuaries provides technical actuarial expertise to public policy makers and maintains the actuarial profession's standards of qualification, practice and, conduct. Academy members include actuaries from all practice specialties: health, life, pensions, and property/casualty.

Academy committees and work groups offer expert testimony, provide technical information, comment on proposed legislation, and work closely with federal and state officials on insurance-related issues. The Academy's Department of Public Policy coordinates the work of committees and work groups with the needs of public policy makers.

INTRODUCTION

Over the past 20 years, the federal government has been attempting to control Medicare health care expenditures, largely by limiting increases in the fee levels paid under the fee-for-service system and by creating incentives for utilization reduction. To control hospital costs, the Health Care Financing Administration (HCFA) has reformulated hospital reimbursement to a diagnosis related group (DRG) system. The result has been a significant reduction in the length of hospital stays. HCFA has recently switched to a resource-based relative value scale (RBRVS) methodology to encourage the use of primary care over specialized care in order to reduce aggregate physician service costs.

This testimony focuses on another approach used by the federal government for cost containment—expansion of health maintenance organization (HMO) contracts for Medicare enrollees.

The testimony begins by briefly summarizing recent trends in Medicare HMO enrollment and commenting on the expected future direction of such trends. It then describes how HMOs are currently reimbursed under Medicare risk contracts and discusses issues surrounding the key element in the reimbursement calculation—adjusted average per capita costs (AAPCC). It concludes by describing a number of different approaches for addressing issues raised by the current risk reimbursement methodology. Among the suggestions made are the following:

- Competitive bidding could be used for setting reimbursement rates. HCFA could determine an average cost that it would be willing to pay, and any balance could be chargeable as a premium to individual Medicare enrollees.

- Provisions for alternative contracting mechanisms could, and probably should, be made for HMOs that are operating in areas where growth in AAPCCs are controlled.

- Adverse selection against some types of health plans and favorable selection toward others will arise when Medicare enrollees are allowed to choose among fee-for-service and managed care options. Therefore, some method needs to be devised for discriminating between risks in calculating reimbursements.

Incorporating these and other suggestions into the current reimbursement system for HMOs could result in a more competitive system with greater government and societal savings. In creating a more competitive system, however the Academy work group is also concerned that care is taken to protect Medicare enrollees' access to quality care. The group suggests that some mechanism be put in place to assure that risk-bearing providers do indeed have the required capital, either directly or through a contracting HMO, to support the risks they undertake.

PAST MEDICARE HMO ENROLLMENT TRENDS

As of April 1995, Medicare's managed care program, called Medicare risk contracts, enrolled more than 2.5 million individuals, or about 7% of the Medicare population. Medicare enrollment in HMO risk and cost contracts were authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). HCFA approval of risk contracts and enrollment did not get under way officially until 1985. Between 1982 and 1985, several risk demonstration projects were set up to establish the process of contracting and rating arrangements.

Prior to the passage of TEFRA, the federal government did hold some HMO contracts called health care prepayment plans (HCPPs), which were set up on a reimbursable cost basis similar to the Medicare hospital reimbursement system used prior to implementation

of the DRG system. During the entire operating period of HCPPs (early 1970s to present), HCFA has allowed HMOs with poor financial success under Medicare risk contracts to switch to HCPP contracts, without federal qualification, or to switch to TEFRA cost contracts. This means that the HMOs that are doing well financially with Medicare contracts can retain their current risk contract status. However, those that do poorly are likely to choose to switch to a contract where their risk is eliminated. This option tends to minimize any chance of cost reduction for HCFA. HCPPs will be mostly phased out at the end of 1995. TEFRA cost contracts will still be an option, however. In April 1995, the number of Medicare eligibles covered under various types of cost programs exceeded 500,000, or 2% of the Medicare population.

Overall, growth in the number of Medicare risk enrollees has been moderate. But as shown in Figure 1 (prepared by the Federal Office of Managed Care) growth in the risk contract market has been accelerating over the past five years.

One reason for the slow growth noted prior to 1991 was the HMO industry's relatively poor economic performance during the mid-1980s. These financial difficulties left many HMOs short of capital, prompting them to become rather non-aggressive in enrolling risky populations and to raise commercial rates substantially in order to strengthen their capital position. Some early growth occurred, however, through the conversion to risk contracts of enrollees in several of the large prepaid group practice plans which had previously been contracting on an HCPP basis.

Growth has also resulted from the many for-profit HMOs that have emerged, largely a result of conversions of not-for-profit HMOs, start-ups, and mergers. These for-profit HMOs have targeted the Medicare population as a major source of new growth and revenue, focusing their marketing efforts in areas that had high concentrations of traditional Medicare fee-for-service system participants, with very high medical costs.

Commensurate with enrollment growth, federal disbursements to Medicare managed care plans of all types exceeded $10 billion in fiscal year 1994. They are expected to exceed $12 billion in fiscal year 1995.

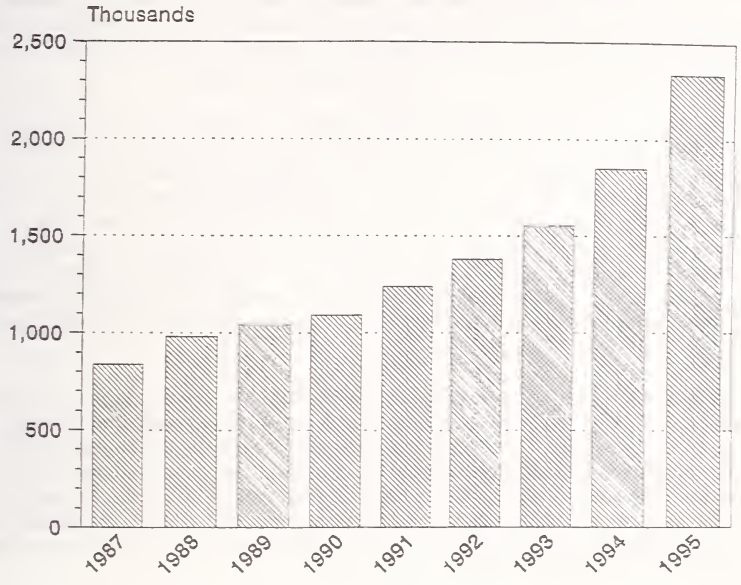
POTENTIAL FOR FUTURE MEDICARE HMO ENROLLMENT GROWTH

HMOs, in general, have been expanding rapidly. The HMO industry estimates that total HMO enrollment is now approximately 56 million, up from the approximately 50 million enrollees at year-end 1994. This growth is expected to continue at least in the near future. In addition, the Medicaid population may become a potential large source of growth. Some states envision prepaid Medicaid contracts as a potential strategy for controlling state expenditures on health care for this population.

FIGURE 1

Growth in Medicare Risk Enrollment

The largest increase in managed care enrollment by Medicare beneficiaries occurs in risk HMOs. Since the inception of the program there has been a steady increase in the number of beneficiaries enrolling in risk HMOs. From 1992-1993 there was a 13% increase; 1993-1994 showed a 19% increase; and enrollment in 1994-1995 grew from 1,848,373 to 2,339,592 - a 27% increase.



Rate of Enrollment Increase

1987	1988	1989	1990	1991	1992	1993	1994	1995
	17%	6%	5%	14%	11%	13%	19%	27%

In the very recent past, there has been a tremendous increase in the rate of growth for HMOs under Medicare. Moreover, Medicare HMO enrollment is likely to continue to increase substantially over the next 20 or 30 years, as many of the employees covered by HMOs during their working years retire. Very few current HMO Medicare members are individuals who "aged into" Medicare HMO coverage. The one probable exception is Kaiser Foundation Health Plans, which started with HCPPs in the early 1970s. These plans have been in business long enough to develop a relatively large aged-in Medicare population. Many of the newer HMO plans just do not have many age-ins, so they must rely on open enrollment for enrollment growth. Nevertheless, over 50 million active employees and their dependents are now covered under HMOs, and, as some of these reach retirement, it is likely that many of them will choose to stay in their HMO, or even shift to a new HMO if they retire to a different geographic location.

Another source of potential growth is smaller HMOs and PHOs. It is becoming more common for insurance-carrier owned HMOs entering into Medicare risk contracting. In addition, though, there are many smaller HMOs establishing additional sites (25 - 50 of these per year), and there is also a potential major expansion of HMO networks, through the nearly 1,000 physician-hospital organizations (PHOs) that have been formed. For example, new hospital ventures, such as in Phoenix and Tucson, have yielded rapid enrollment of great numbers of Medicare enrollees. In this competitive environment, many hospitals are striving to retain their share of Medicare enrollees by entering into Medicare risk contracts—either directly as an HMO, or by subcontracting with a federally qualified HMO or competitive medical plan.

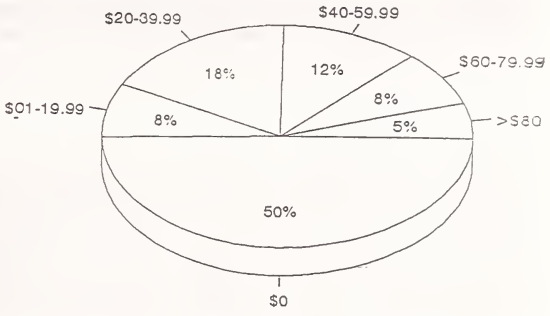
Competitive forces favor an expansion of HMOs and may encourage more Medicare enrollees. In the HMO industry, commercial premium rates have been falling for nearly two years, and many expect that rates will fall even more sharply by the beginning of 1996. Insurance carriers and HMOs are lowering rate quotes sharply on large-employer groups to increase their market share. Some analysts think that we are in the beginning of a dramatic downturn in profits for the prepaid health care industry, although the results would certainly be worse for straight indemnity plans than for HMOs, which have capitation contracts and negotiated low prices.

During the past several years, particularly in 1994-95, there have been sharp reductions in Medicare risk contract supplemental premiums. These premiums are the amount above HCFA's capitated rate that enrollees are required to pay for themselves. Figure 2 shows that approximately 50% of the contracting HMOs have a zero premium (except for supplemental benefits); 56% of Medicare enrollees are in zero premium plans. With indemnity, Medigap, or employer premiums exceeding $100 per month, it is not surprising that employers are building in incentives for their retirees to join HMOs, which have far more modest premiums.

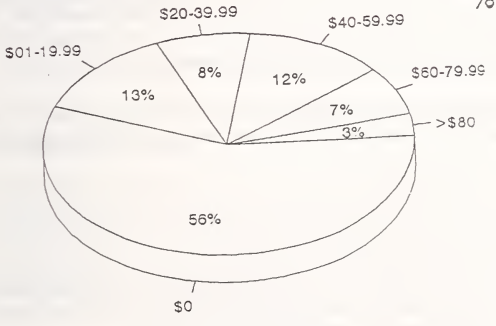
FIGURE 2

Range of Premiums for Medicare Population Covered by Risk Contracts

Premiums in Medicare risk contracts range from $0 to $110 per member per month. Sixty-six plans offer beneficiaries health care coverage for no monthly premium; 12 charge up to $19.99 a month; 26 charge $20 - $39.99; 15 charge $40 - $59.99; 11 charge $60 - $79.99; and only 6 charge in excess of $80. The majority of Medicare enrollees in HMOs incur little or no out-of-pocket expenses for HMO coverage. This coverage generally includes non-Medicare-covered services, such as preventive care, immunizations, outpatient drugs and eye exams.



% Plans



% Members

A note of caution is appropriate here. The increased competition and increased pressure for Medicare recipients to enroll in HMOs may also generate increased risk. Outcomes for the HMO industry have been favorable, and competitive pricing appears to be at its peak. However, new players who are entering the market are potentially at risk for not having sufficient knowledge about running an HMO or the capital to withstand a negative result under Medicare risk contracting.

REIMBURSEMENT METHODS FOR MEDICARE HMO CONTRACTS

Medicare risk contracts reimburse HMOs based on a capitation rate that varies for each county and is adjusted for simple risk factors, including age, sex, total disability (under age 65), Medicaid eligibles, and institutionalized members (residents of nursing homes). These capitation factors are called the AAPCC (adjusted average per capita costs) and are derived from total Medicare Part A and Part B costs for the Medicare population (excluding enrollees with end-stage renal disease).

The cost for each county is adjusted by taking the five-year average cost per capita for that county and dividing by five-year average national per capita costs, to arrive at a stable relationship. Average costs are then expressed by adjusting for the differences in the population cells, by risk factor, in each county, to produce a comparable standardized factor for the aged and disabled. There are large fluctuations in the rate of change each year in county-level costs. This makes it more difficult for HMOs to predict short-term and long-term costs accurately. Projecting AAPCCs is subject to projection error, with projections sometimes being above or below what the actual experience will be. In general, however, these projections are higher than actual experience. As a result, HMOs are, on average, reimbursed at a higher rate than their actual costs.

There are two major sets of issues with the current AAPCC method that need to be addressed. One has to do with the compensation rate and the other with geographic fluctuations.

Compensation Rate Issues

Since the amount paid to HMO risk contractors is 95% of the projected fee-for-service cost, even if the HMO were to save a great deal of money by operating at a much lower cost, it would not save the federal government any additional money. HMOs with costs below the federal reimbursement are allowed to add benefits, to an unlimited point, and to use up whatever savings it may have accrued from having lower costs than the average fee-for-service Medicare cost, thus reducing out-of-pocket costs for Medicare beneficiaries.

Each HMO is required to submit an annual adjusted community rate calculation to HCFA, which sets an upper limit on the premium that the HMO may charge. In some cases, this limit distorts the rates because HMOs are required to use HCFA's estimates for the cost of covering deductibles and coinsurance, rather than cost factors based on the HMO's own experience. In competitive areas, HCFA should consider allowing HMOs to increase their supplemental premiums without constraint.

Geographic Fluctuation Issues

The AAPCC varies considerably by geographic area. One reason for this is the large variation in fee-for-service Medicare costs. For example, there is an approximately threefold variation, with some Medicare metropolitan areas now approaching $700 per month per Medicare eligible and costs in some rural areas of between $200-$300 per month per Medicare eligible.

In areas with a high concentration of HMOs, in some cases exceeding 50% in a given county, it is not clear that the AAPCC formula will produce a fair capitation rate. Research has shown that some areas with high HMO penetration of the Medicare market experience a lower rate of Medicare spending increases, in aggregate. Major mathematical adjustments are required to calculate the AAPCCs in the normal form, when the large majority of the Medicare population in certain age/sex cells will be enrolled in HMOs. This situation seems to be particularly problematic when there is no good method of counting residents of nursing homes or Medicare eligibles also on Medicaid, who may go in and out of eligibility frequently.

METHODS OF ADDRESSING CURRENT HMO REIMBURSEMENT ISSUES

Competitive Bidding

Most HMO enrollees tend to live in high-cost areas, where effective management controls may more easily produce profits for the HMO, but little savings to the federal government. It would appear that some other basis for reimbursing HMOs is necessary, to circumvent the multiple problems that stand in the way of the two goals of equity and achieving savings for the federal government.

Many experts suggest trying competitive bidding in some area where there are three or four HMOs and a high HMO penetration of the overall marketplace. The HMOs would not be restricted to an AAPCC, but may instead bid any price they choose. HCFA could determine an average cost that it would be willing to pay, and any balance could be chargeable as a premium to the individual Medicare eligible.

If competitive bidding is used, it may be necessary to require that all HMOs in the market use risk contracts, and not be allowed to use cost contracts (This will not be an issue after year-end 1995 because most cost contracts will be phased out.). With a competitive bidding environment in high-cost areas, HCFA should consider allocating a portion of true savings to increase the payments to the HMOs in low-cost areas.

Compensation Rate

To the extent that restricting reimbursement rates in the fee-for-service sector reduces the federal government's cost, it tends to lower the amount of reimbursement that would go to HMOs under the current system. This may be problematic because HMOs may not be able to reduce their costs by a large enough margin to reduce federal government outlays for Medicare contracts. HMOs may find it difficult to renegotiate physician and employee fees and continue to reduce the current hospital reimbursement rates below the federal reimbursement rate. To the extent that the increases in AAPCCs are controlled, HMOs must be able to operate within that rate in order to enter into contracts successfully.

Adjusting for Annual Fluctuations

Attempts to smooth the income flow, and methods for retroactive adjustments, have been discussed, but never negotiated. Concern for budget neutrality and the difficulty of recapturing overpayments to HMOs appear to have stalled discussions.

Health Status Adjusters

While many HMOs have tried to implement a health status adjuster (HSA) system, the administrative requirements have proved formidable, and the HCFA capitation rates have changed frequently as medical histories are updated.

Many researchers have investigated the possible effect of factors such as prior disability, variations within geographic regions, and changes in use patterns in rural areas under HMO coverage, and adjustments for the working aged. But most studies have focused on the result of significant differences in prior hospital utilization or ambulatory care diagnoses. Because of these efforts to develop HSAs for Medicare, many states, such as Minnesota, require HSAs for populations subsidized under universal health care legislation.

Although Congress may propose other methods of controlling Medicare costs, as well as other options for enrolling Medicare eligibles, we need to bear in mind that the issue of adverse selection (or favorable selection) for one of the options will lead to more problems if more options are offered, since smaller populations will be selecting in order to maximize

their own advantage. Some studies have shown instances where there appears to be a level of favorable selection for HMOs, whether intended or otherwise. These studies also reveal that Medicare eligibles willing to join an HMO have had lower historic costs compared with similar non-HMO Medicare eligibles, or that the health status in the average Medicare population is worse than the average health status of the HMO enrollees. Other studies comparing the health status of the Medicare HMO population with the general Medicare population have not indicated that the health status of HMO enrollees is superior.

When allowing Medicare enrollees to choose from among multiple options, therefore, it may be even more crucial to devise some method, such as HSAs, of discriminating between risks. These should be set up as pilot programs until the actual pattern of selection can be determined. In addition, if a competitive bidding process is implemented, bidders may want to include some type of catastrophic reinsurance or HSA system to protect them from enrolling a high-risk population on a random basis.

HMO CREDENTIALING

One of the major elements in continuing federal regulation of HMOs is credentialing. Credentialing is intended to monitor the quality of care, grievance systems, and outcome measurements. To the extent that we are putting in place a more competitive system, we should also be concerned about protecting Medicare eligibles' access to quality care during a period of premium restraint and competitive bidding. It should also be determined that risk-bearing providers do indeed have the required capital to support this risk, either directly or through a contracting HMO. The National Association of Insurance Commissioners is developing formulas for all types of health organizations to develop risk-based capital requirements on a consistent basis.

CONCLUSION

With industry and government cooperation along the areas outlined above, the Academy work group believes that the HMO industry could greatly expand its enrollment of Medicare eligibles in a cost-effective way. This approach could produce savings to the federal government, while at the same time preserving access to quality health care at competitive cost for Medicare beneficiaries. Members of the Academy's Medicare Work Group are available to discuss these and related issues.

STATEMENT OF THE AMERICAN REHABILITATION ASSOCIATION

SUBMITTED TO THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS

FOR THE RECORD OF THE HEARING ON MEDICARE ISSUES
- INCREASING AND IMPROVING OPTIONS FOR MEDICARE BENEFICIARIES -

MEDICARE HMO ENROLLMENT GROWTH AND PAYMENT POLICIES

MAY 24, 1995

MEDICARE MANAGED CARE: CONSUMER PROTECTION STANDARDS

Mr. Chairman:

This testimony is being submitted on behalf of the American Rehabilitation Association for inclusion in the record of your subcommittee's hearing on managed care and the Medicare system.

The American Rehabilitation Association (formerly NARF) is the largest not-for-profit organization serving vocational, residential, and medical rehabilitation providers in the United States. The established leader in the field of rehabilitation for more than a quarter of a century, American Rehab services its more than 800 member facilities by effecting changes in public policy, developing educational and training programs and promoting research. In addition, it provides networking and communications opportunities, all of which helps to ensure quality care and access to services to more than four million persons with disabilities each year.

All of us will probably need at least one rehabilitation service sometime in our life. As we go about our daily lives none of us contemplate if we will have a stroke, break a hip, hit our head, have a spinal cord injury, be shot or stabbed or have a child born with a congenital problem. We do not think about this as our future. But for many Americans, unexpectedly and unfortunately these things happen. These types of illnesses or injuries require rehabilitation services to help return people to home, to work, to school and ideally to an active life. For a child born with a congenital or genetic disorder, rehabilitation services can help them walk, move, write, feed themselves, and therefor attend school, participate in social events and enjoy the kind of life that most of us think is what life is all about.

PURPOSE

The number of people who obtain health care coverage through various types of managed care plans is growing. It is an article of faith among many policy makers that "managed care" is the appropriate, if not the only, way to slow the rate of growth in health care expenditures. Managed care plans, primarily health maintenance organizations, are replacing indemnity carriers as the insurer of choice for many corporations. State Medicaid programs increasingly are using managed care in one form or another. Various members of Congress are advocating the provision of incentives for enrollment in managed care plans by Medicare beneficiaries as a means of reducing costs (or at least reducing the rate of increase of costs) of the Medicare program.

In concept there are two reasons why managed care plans can provide care at lower cost than traditional forms of insurance and health care delivery. First, it is assumed that by hiring or contracting with providers of services to significant patient populations, HMOs and other managed care plans can achieve economies of scale (or drive hard bargains). Second, through "management" of care through gatekeeper physicians and other controlling mechanisms they can avoid delivery of ineffective or superfluous services and, thereby, avoid the associated costs.

In fact, there is a third factor, denial of services. Enrollees may find that certain services are not provided, either because they are deemed to be unnecessary or because of contract limitations, the effects of which are not appreciated until it is too late. This observation is not to suggest that HMOs and other managed care plans seek to deceive enrollees, but rather that certain specialty services which are utilized by a small number of enrollees do not receive adequate attention by either the plan or the enrollee until the service is needed.

This is often the case for rehabilitation services. Rehabilitation is designed to restore or improve physical and cognitive function after a disabling event or illness. Typically disability is produced by traumatic injury, stroke or neurologic disease or congenital problems. The ability to walk, talk and perform activities of daily living can be restored or enhanced through a coordinated program of therapies and other services. Depending on the medical condition of the patient, such services may be provided in a rehabilitation hospital or unit, a skilled nursing facility, on an outpatient basis or in the home.

This testimony provides a brief overview of the treatment of rehabilitation by managed care plans and suggests ways in which present or potential enrollees may make informed decisions about a managed care plan's coverage of same.

BACKGROUND

Managed care plans do not always fully delineate the scope and duration of covered services, explicitly state what is or is not covered, disclose incentives for or against use of various services or provide mechanisms for resolution of disputes with enrollees about the need for services. Relatively few people utilize rehabilitation services in a given year; about four million people receive some type of therapy service annually. Of this total about 400,000 are admitted to a rehabilitation hospital or a rehabilitation unit in a general hospital. Thus, the chance that a given individual will need rehabilitation services is slight.

While HMO Medicare plans are to cover all Medicare benefits, when the need for rehabilitation services does arise, enrollees find that managed care policies frequently limit or restrict access to services. To avoid such circumstances managed care plans should provide adequate information to consumers to enable them to understand what they have purchased and their rights in case of disputes about the need for services. These issues will arise in the 104th Congress as consideration is given to restructuring the Medicare program.

This means that coverage of such services is not a major consideration when a choice is made to enroll in a managed care plan. When the need for rehabilitation services does arise, enrollees find that contract limitations or managed care policies bar or limit access to services. To avoid such circumstances managed care plans should provide adequate information to consumers to enable them to understand what they have purchased and their rights in case of disputes about the need for services. These issues will arise in the 104th Congress as consideration is given to restructuring the Medicare program health insurance reform, and Medicaid and ERISA waivers.

The Association has heard repeatedly about instances where Medicare beneficiaries are not referred for rehabilitation services or where services have been limited in duration, not allowing for maximum or (even adequate) functional recovery, or, the site of services is inappropriate. Most recently the Association heard of a group of physicians who in preparing their profile in order to contract with local HMOs, refused to refer a patient with a hip fracture and prothesis to a local rehab hospital. The hospital had a critical path for such patients whereby the patient would be sent home, walking within in one week, or less. The physicians, wanting to theoretically save money, sent the patient to an alternative site where the patient never got out of bed; received only bed side physical therapy; developed serious pressure sores and the cement on the prothesis cracked. He was readmitted to the acute care hospital and receive another hip prothesis, after the complications of the pressures sores were corrected. Then he was referred to the rehab hospital. While the physician's profile may not show the readmission and subsequent rehab referral, the Medicare program had to bear the cost of this decision, the readmission and the complications that could have been avoided.

Also, an American Rehab study of HMO coverage of rehab services found that one-half of the facilities that have Medicare contracts reported that the HMO does not refer to rehab hospitals

or units. Several studies raise concerns about HMO treatment of Medicare beneficiaries as well. The Medicare Advocacy Project, Los Angeles, California, in its January 1993 report, "Medicare Risk Contract HMOs in California: A Study of Marketing, Quality and Due Process Rights" noted the failure to refer for needed specialty care; not having enough contracting specialty physicians available or having financial incentives to delay or prohibit referrals to specialty physicians; and failure to refer for rehabilitation. Additional studies by MATHEMATICA, Inc. have raised similar concerns.

These issues reflect several points.

1. Managed care plans enrolling Medicare patients are required to provide at least the same coverage as the Medicare fee for service. There is no 60-day limit on inpatient rehabilitation service under Medicare, as there may be for non-Medicare enrollees.

2. Most stated coverage assumes advance approval by the managed care plan and/or "continual functional improvement". The standards to be applied in making such judgments are not stated, leaving grounds for dispute between enrollees and the plan in question.

3. There is no disclosure of incentives for gatekeeper physicians and other representatives of a plan to provide or withhold care.

Additionally, several studies have found that rehabilitation services are restricted or limited. For instances, at the request of HCFA, MATHEMATICA Policy Research, Inc. conducted a study to assess whether this risk program proved to be cost-effective and whether the delivered care of HMOS was of comparable quality to that provided by FFS providers. A report of the study, ***Does Managed Care Work for Medicare? An Evaluation of the Medicare Risk program for HMOs***, was released by MATHEMATICA Policy Research, Inc. in December 1993.

The results indicated that the risk program does not save money for HCFA and, in fact, costs are higher than they would have been had the enrollees not joined the HMOs. Costs under the risk program were 5.7% higher than they would have been under the FFS because beneficiaries with chronic health problems were less likely than healthy beneficiaries to enroll in HMOs, and the payment (capitation) rates failed to reflect this favorable selection fully. Although payment rates to HMOs were set at 95% of HCFA's projected FFS cost for enrollees, these projections were too high, by about 11% on average. HCFA's simple method of basing the payment rate for individuals on their age, gender, and a few other readily available characteristics fails to account fully for the healthier-than-average mix of beneficiaries who choose to enroll in HMOs. Thus, instead of saving 5% as intended, HCFA spent nearly 6% more than it would have for enrollees had they not joined the HMOS.

Another study, ***The Quality of Care in TEFRA HMOs/CMPs***, was released in December of 1992. This study found that overall medical care for strokes and colon cancer was comparable to that in the fee-for-service sector. Any reduction appeared to be influenced by patient severity. Therefore, the researchers found that HMOs were cutting costs for these patients who needed the services least. In terms of speech and physical therapy visits for stroke patients, HMO enrollees tended to receive fewer services and were discharged with greater deficits than non-enrollees.

These excerpts from various managed care plans reflect three points of likely confusion.

1. First, overall limitations are framed in terms of time or number of days of services per condition, leaving considerable ambiguity about what constitutes a condition.

2. Second, managed care plans enrolling Medicare patients are required to provide at least the same coverage as the Medicare fee for service. There is no 60-day limit on inpatient rehabilitation service under Medicare.

3. Third, most of the coverage stated assumes advance approval by the managed care plan and/or "continual functional improvement". The standards to be applied in making such

judgments are not stated, leaving grounds for dispute between enrollees and the plan in question.

4. Fourth, there is no disclosure of incentives for gatekeeper physicians and other representatives of a plan to provide or withhold care.

DISCLOSURE OF REHABILITATION COVERAGE

For these reasons, the Association recommends that managed care plans enrolling Medicare beneficiaries fully describe coverage of rehabilitation services and that any limitations on such coverage be clearly delineated. The following principles are recommended for inclusion in any legislation designed to foster the use of managed care plans by Medicare beneficiaries and others.

1. Plan Information

Plans should provide uniform written descriptions of their benefits, services and procedures that clearly and fully disclose limitations of coverage, exclusions and out-of-pocket costs, including copayments, deductibles, coinsurance, and established aggregate maximums on out-of-pocket costs.

2. Assessment

Primary care providers should perform a rehabilitation evaluation within 72 hours of seeing patients who fall into the diagnoses most commonly treated by rehabilitation, and who have a specific functional level as measured by a common rehabilitation assessment tool.

Then if an enrollee is a candidate for rehabilitation and meets the existing Medicare inpatient rehabilitation hospital or outpatient guidelines he or she should have access to and be referred for those services.

3. Quality

Managed care plans should be accountable for the quality of care provided. They should ensure adequate access to services for all their enrollees. Outcomes, both medical and functional, should be reported by plans to the government and to enrollees.

To do so, plans should have mechanisms in place which measure quality, access and outcomes. This would include: (a) functional improvement; (b) maximum waiting periods for appointments, both initial and followup, and for referrals to specialists; (c) maximum travel distances; (d) readmission to the hospital; and (e) submission of data to the public on outcomes to assess the cost and quality of health care.

4. Specialists as Gatekeepers

Enrollees who require ongoing, specialized health services should be able to choose a specialist as a gatekeeper in order to effectively manage the services appropriate to their conditions. Relevant specialists should also be directly available to enrollees without gatekeeper approval where continued specialized care is medically indicated.

Physician referrals to physician and non-physician specialists should be based solely on the needs and desired outcomes of the patient.

5. Point-of-Service Option

This provision is critical to allowing persons with specialized health care needs to obtain care from out-of-network providers, assuming they opt to pay the extra premium and co-payments as necessary. It retains the ability of closed-panel HMOs to contain costs, but

also allows enrollees the flexibility to opt out of the provider network if they pay a little more for this option.

6. *Consumer and Provider Due Process*

Plans should set forth procedures to be followed in the resolution of disputes with enrollees about required services and the adequacy of those provided by the plan. Grievance mechanisms should be timely and fair.

Grievance and appeals procedures should:

a) be available to both enrollees and providers, including timely review of a service denial;

b) be clearly communicated to all parties;

c) require independent second opinions to be obtained promptly when covered benefits are denied for any reason;

d) require an expedited appeals process leading to a decision within 72 hours of the initial complaint.

7. *Arrangements with Providers*

Plans should enter into agreements and other arrangements to ensure an appropriate mix, number and distribution of qualified health professionals to adequately provide for the plan's benefit package.

8. *Utilization Management Protocols*

Utilization review should be performed by qualified personnel knowledgeable in the field in which a coverage decision is being made. Qualified health professionals, including rehabilitation providers and other specialists, should be involved in the development and implementation of utilization review procedures and practice guidelines.

9. *Consistency*

Plans should be consistent in the information required, i.e., data elements and methods of analysis, evaluation criteria, assurance of non-discrimination among classes of providers, uniform quality and utilization standards, outcomes assessment, assurance of access, fair and adequate reimbursement, consistency of record-keeping requirements.

10. *Case Management*

Life plans (long term care planning) should be developed for individuals with chronic or catastrophic conditions in consultation with the individual and family members.

STATEMENT OF

AMERICAN SOCIETY OF PLASTIC
AND RECONSTRUCTIVE SURGEONS

to the

Committee on Ways and Means
United States House of Representatives

June 8, 1995

RE: Medicare HMO Enrollment Growth and Payment Policies

The American Society of Plastic and Reconstructive Surgeons (ASPRS) represents 97% of the nearly 5,000 board certified plastic surgeons in the United States. Plastic surgeons provide highly skilled surgical services which improve both the functional capacity and quality of life of our patients. These services include the treatment of congenital deformities, burn injuries, traumatic injuries, and cancer.

I. Background

Enacted in 1965, Medicare has proven to be a great success in improving the health status of the elderly and disabled, keeping them in the mainstream of American medical care. However, Medicare suffers budgetarily due to its fundamentally flawed financing structure and erroneous budget projections.

According to an April 3, 1995 report by the Social Security and Medicare Boards of Trustees, Medicare's Hospital Insurance Trust Fund is projected to be insolvent by year 2002 and will pay out more than it takes in beginning in 1996. This warning comes after several years of severe cuts in Medicare's physician payments. Physicians account for 23% of Medicare outlays, yet have absorbed 32% of provider cuts over the last decade. Even with these levels of cuts, for years 1991-93, physicians have succeeded in actually holding down volume increases below projected levels, thus saving the program billions in projected dollars.

In response to the recent insolvency projection and in an attempt to reduce the federal budget deficit, Congress has begun to consider restructuring the Medicare program along with further proposed reductions of $250-300 billion over the next seven years. Some are projecting as much as $100 billion in savings to come from expanding managed care into Medicare program, although the Congressional Budget Office (CBO) is skeptical about managed care programs generating any significant amount of savings.

II. Expanding Managed Care to the Elderly Population Will Not Result in Savings for Medicare

A number of policy-makers and academics have cited the potential of managed care to generate significant savings from Medicare and slow the rate of growth of the program. Managed care is premised on the notion that effective case review can lower overall costs without affecting the quality of care provided. However, it is highly unlikely that managed care will be the panacea for Medicare's financial crisis nor does it adequately serve the program's bottom line.

In the private sector, managed care has produced one-time savings through provider discounts, but has not slowed the long-term rate of growth of health care expenses. As for serving an elderly population, studies have consistently shown that Medicare managed care programs do not save the government money and do little to address the long-term problems

facing Medicare. Experience of the Medicare risk contract program confirms that the healthiest segment of Medicare beneficiaries tend to enroll in managed care, while the older and sicker beneficiaries do not appear willing to change doctors or give up their freedom to choose a particular specialist or hospital.

In testimony to the Senate in February, the CBO testified that HMOs attract healthier members of the Medicare population and "there may also be a tendency for HMO enrollees to switch to the fee-for-service alternative when severe health problems arise." When sicker beneficiaries return to the fee-for-service pool, the HMOs are relieved of the costs associated with providing the patient with advanced services and necessary equipment. This favorable selection holds down the managed care plans' expenses, but can result in major losses to the Medicare program overall.

A 1994 General Accounting Office report explains that "as more healthy beneficiaries join HMOs, the Medicare fee-for-service population on average becomes sicker, driving up Medicare's average costs of treating fee-for-service patients. When this average cost rises, so does the capitation rate HCFA pays to risk contract HMOs."

Favorable selection results in Medicare over-paying managed care to treat the healthy and then being forced to swallow the costs of the older and sicker who return to fee-for-service in the later stages of life.

There is no reason to believe that expanded enrollment in Medicare managed care programs will prevent favorable selection. The GAO concluded last year that "favorable selection is not likely to disappear once larger numbers of Medicare beneficiaries are enrolled in HMOs."

III. Managed Care Lacks Capacity to Serve Entire Nation

There are also limits to the ability of managed care programs to serve rural areas that do not contain sufficient population to sustain effective HMO competition. After all, nearly one in three Americans live in such rural areas. According to a study published in the New England Journal of Medicine, communities with less than 180,000 people may be too small to support effective competition among managed care providers.

HCFA Administrator Bruce Vladeck cautioned that "the movement toward managed care cannot outpace the capacity of managed care plans to serve large numbers of new enrollees, particularly those with expensive and special health needs of the Medicare population."

IV. Managed Care is Not Suited to Handle Unique Health Needs of Elderly

Cost is not the primary concern of the elderly. This reduces their sensitivity to pricing and their tolerance for slower, less tailored care. The special health needs of Medicare enrollees place them at higher risk for failure of managed care to provide timely access to needed care. The drive to hold down costs may threaten the health of senior citizens enrolled in the program. Numerous studies have cautioned about the adverse effects of HMO participation by the elderly. In responding to financial pressures to provide care at a low cost, HMOs may restrict care too much, leading to lower quality care. In recent years, seniors have expressed their dissatisfaction with Medicare managed care by disenrolling from the Medicare risk program in large numbers.

A study published in the May 1994 issue of the New England Journal of Medicine questions the ability of managed care to treat chronic conditions prevalent within the Medicare population. The study suggests that HMOs may be ill-suited to handle the needs of individuals with conditions that demand extended and repeated medical attention.

It is not realistic to assume that managed care delivery systems will effectively serve our seniors. As retirees grow older and sicker, they become increasingly dependent on ready access to specialists and treatment of their choice. Their expanded reliance on prescription

drugs and advanced treatments will put them at odds with organizations that are under pressure to look squarely at the bottom line. An 1994 study of HMO performance warns that little evidence exists that the performance of prepaid care in relatively healthy populations can be replicated among sicker patients.

V. Medicare Changes Should Encourage Personal Responsibility in Health Care Spending

Further short-term reductions of expenditures and the expansion of managed care will not solve Medicare's budgetary problems. The Medicare program requires serious, long-term transformation if its promise is to be preserved for future and current generations.

Any formulation of a long-term solution should include the principles of enhancing inter-generational equity in financing, reducing regulatory and administrative complexity for patients and physicians, and facilitating price competition among physicians.

Moreover, we believe that a crucial component in reducing the rate of growth in the cost of Medicare and health care in general is encouraging personal responsibility and cost-consciousness at the point of service.

In restructuring Medicare, a possible solution for Congress is to provide the same tax incentives for Medical Savings Accounts (MSAs) as given traditional employer-paid health benefits.

The enactment of MSAs, as proposed in various bills pending in Congress, would be an important step in moving away from the current system of first-dollar coverage provided by third parties, and toward returning control over health care spending to individuals and decreasing costs by lowering utilization. ASPRS welcomes chairman Bill Archer's initiative in this area and encourages the committee to develop this approach concurrent to its changes in the Medicare program.

VI. Medicare Patients Enrolled in Managed Care Should be Provided With Certain Protections

To the extent that managed care expands within the Medicare program, ASPRS strongly believes that beneficiaries should be provided with formal safeguards to ensure that the profit motive does not endanger patient care. Also, seniors should be fully informed about the coverage, restrictions and procedures of various plans.

To protect Medicare patients enrolled in managed care from potential abuses of managed care, ASPRS recommends that Congress adopt the following safeguards:

- Financial incentives should not be allowed to interfere with medical judgment. For instance, plans should be prohibited from establishing arrangements in which the gatekeeper has a financial incentive to not refer patients. The patient's first point of contact should be encouraged to make all needed medical referrals and should not feel constrained financially from doing the best job for the patient;

- Point of service options should be mandatory for all plans with limitations on out-of-pocket expenses to patients. Patients should be able to opt out of any closed system to seek the specialist of their choice. The financial penalties that accrue to such an opt out, or "point of service" should be capped. This option is the ultimate consumer protection against poorly managed health care plans, or those that unduly restrict access to necessary specialty treatment;

- Plans should be required to provide the full range of specialized care for enrollees with rare, unusual or highly complex conditions, and should provide all appropriate specialty services in accord with clinical practice guidelines established by recognized specialty societies. Direct access to specialty care is essential for patients in

emergency and non-emergency situations, and for patients with chronic and temporary conditions, as well as those with unexpected acute care episodes. Specialty care must be available for the full duration of the occurrence, and not limited by time or number of visits;

- Beneficiaries should have the ability to disenroll from managed care programs at any time. This would provide an important incentive for plans to provide high quality care;

- All plans participating in the Medicare program should be evaluated in a consumer "report card" in part on the basis of the timeliness of access to specialty care and the quality of that care as established through the credentials of the physicians and the outcomes of their treatments; and

- Plans should provide potential enrollees with clear information about the services covered and excluded, and information on patient satisfaction with the particular plan.

VII. Conclusion

ASPRS is opposed to proposals to expand managed care to the Medicare population as such a move will not result in savings for the program, while risking the health of the elderly.

The Medicare program should be restructured to encourage personal responsibility in health care spending and decrease reliance on third-party payment. Enactment of MSAs is important to accomplishing this objective.

Medicare patients enrolled in managed care should be provided with safeguards protecting their quality of care, access to necessary specialty services, and ability to disenroll from a particular managed care plan.

ASPRS appreciates the opportunity to testify on the topic of Medicare before the Senate Committee on Finance, and is available as a resource on this issue as the Committee continues its work.

Coalition of Mental Health Professionals and Consumers, Inc.
P. O. Box 438, Commack, NY 11725 Phone/Fax: 516-424-5232

Testimony

Karen Shore, Ph.D., Executive Director
1966 Ashley Place, Westbury, NY 11590
516-997-3390

A) Introduction:

I am submitting testimony on behalf of the Coalition's approximately 1250 members. The Coalition is a national, grass-roots organization, made up of clinicians from all mental health disciplines and consumers of mental health care, their family members, and their advocates. The Coalition is working with approximately 24 regional "affiliated groups" that have no legal tie to the Coalition, though some have taken out memberships. Thus, I am not officially testifying for these groups, but do want the Subcommittee to know that several of these groups are state or regional Coalitions (MA, NY, NJ, PA, DE, MD, NC, GA, TN, IL, OH, CO, CA, WA, MO) that have been inspired by our Coalition or that formed prior to our forming (November, 1992), have similar goals, and are attempting to work together. Each of these groups may have dozens, hundreds, or thousands of members.

I am testifying because of plans to increase the number of Medicare beneficiaries to be enrolled in HMO's and other forms of managed care. The Coalition formed specifically because of the decline in quality of mental health treatment brought by managed care organizations (MCO's). MCO's also have a strong impact on the ability of professionals to deliver proper care. The problems of managed care have the most impact on beneficiaries who need treatment, as opposed to those who are generally healthy. Thus, a larger percentage of the Medicare population covered by MCO's than of the general MCO population will experience these problems, as our elderly generally require more treatment than does the general population.

In this testimony, I will outline the problems we have seen in delivery of services under MCO's in the private sector and will offer recommendations. We cannot assume that Medicare beneficiaries will receive better care under MCO's than those in the private sector.

B) Problems with Managed Mental Health Care for Consumers and Providers:

1. Citizens lose the right to freely choose clinicians and treatment facilities.

a) MCO's increasingly limit their provider list to providers who demonstrate a willingness to perform short-term treatment, whether or not it is truly appropriate, and on their willingness to do so without complaint. Thus, the pool of providers available to the consumer may exclude those who would perform or advocate for quality care.

b) Primary care providers often must act as gatekeepers and may limit access to psychiatrists and to psychotherapists. Often, there are financial penalties if primary care providers make "too many" referrals. Corporate profits are often more important than the consumer and treatment. Primary care physicians are asked to do "counseling," but do not have the training to do real psychotherapy.

c) MCO panel limitations often cause the consumer to travel a great distance for their care, which could be especially burdensome for the elderly, and may prevent needed care.

d) Consumers may have to change clinicians often as plans drop providers and merge with other MCO's, or as the consumer changes health plan. Continuity of care and the building of trust in the clinician are impeded. Continuity of care and trust may be particularly important for the elderly, who often are more in need of ongoing treatment than the general population.

e) Clinicians are impeded in their ability to make the best referral possible due to panel restrictions preventing them from referring "out-of-network."

f) Generally, psychiatrists and other doctoral-level clinicians, and even master's level clinicians, may be prevented from performing psychotherapy by MCO's, as MCO's often search for the "cheapest" clinicians. One MCO reportedly has begun using bachelor's level counselors rather than professionally trained master's and doctoral level professionals. When beneficiaries cannot receive reimbursement for treatment by clinicians with advanced training, quality of care is compromised.

g) Patients hospitalized in a non-network hospital in an emergency may be forcibly transferred to a network hospital before they are well, impeding recovery and possibly increasing symptoms.

h) Even if the MCO offers out-of-network benefits (Point-of-Service Option), consumers with limited incomes may be unable to access out-of-network providers, as they are financially penalized for doing so. This may affect the elderly in large proportions due to the large percentage on limited incomes.

2. Patients lose the right to make their own treatment decisions.

a) The MCO may pre-determine that all or most patients are to receive brief hospitalizations and brief, crisis-focused psychotherapy, regardless of patients need. This is based on decisions about money, not treatment and consumer need.

b) The MCO often requires reports from the treating clinician and then takes over treatment decisions. The patient and his/her clinician may be powerless to decide the course of treatment. The sense of powerlessness and the prevention of access to proper treatment may increase a patient's symptoms, especially depression and anxiety. Hospitalization or intensive psychotherapy for a particular patient may be declared "not medically necessary," even though the standards of practice in the professions would clearly show the need for treatment.

c) What is "medically necessary" varies from one MCO to another, as it generally has more to do with costs than with care.

d) Many MCO's will only authorize three or four psychotherapy sessions at a time, leaving the beneficiary and provider unable to know how long their work will be able to continue. Anxiety often rises before each "approval" and session time is often spent on discussing the MCO, rather than on the problem for which the patient sought treatment.

e) Some MCO's deny funds for psychotherapy if the patient refuses medication. This is because medication may produce a fast relief of symptoms, even though it may actually fail to correct the actual problem. This then allows the MCO to discharge the patient without investing much money. In general, there is concern that too many of our elderly are already over-medicated. Often, they are considered too old to make changes and not good candidates for psychotherapy, which is not necessarily true. This puts the elderly at increased risk of over-medication. Further, there is a bias among some physicians and scientists toward medication and away from "talk therapies," but this may reflect little more than an honest bias and the difficulty of forcing "talk therapy" into the molds of empirical science. Patients may have a strong need to talk out their problems, yet their voices do not count under managed care.

3. Consumers lose the right to privacy under managed care.

Because reports must be submitted to the MCO by the provider in order for the MCO to determine whether or not continuing care is "necessary," information that should not leave the treatment room must be given to the MCO, which may store it in their data banks. Psychotherapy patients often require privacy over information involving personal problems. Many consumers are not at all comfortable allowing such information to be divulged, but may have to sacrifice reimbursement if they withhold this information. Under Medicare, psychotherapy providers are not permitted to treat beneficiaries outside the plan. Thus, those requiring privacy or those with paranoid conditions may be forced to forego needed treatment due to inappropriate cost-containment techniques that may be suited to "industry," but not to human services.

4. MCO's may be grossly under-treating consumers of mental health care due to cost-containment. Because it is illegal for psychotherapists to provide treatment for Medicare beneficiaries outside of Medicare, those consumers who need treatment beyond what the MCO dictates may be prevented from legally obtaining needed services.

a) Many MCO's provide a grossly inadequate model of "short-term therapy," "solution-oriented therapy," "crisis intervention," or "stabilization," or they may state that they only treat the "acute phase" of a problem, refusing to pay for proper treatment for "chronic" or "ongoing" problems. This is a standard that would never be tolerated in medical care, and should not be tolerated in mental health care. Examples of MCO literature stating these limits can be provided to the reader.

b) Many patients need time to build trust in the clinician and to tell their story. Patience and understanding from the clinician are as necessary as advice. The clinician needs to spend enough time with the patient in order to know if the problem goes deeper than the surface "presenting problem." These things are too often impossible under managed care.

c) MCO's are misusing research data by not speaking to the limits of the research in order to support their bias toward short-term treatment.

d) Even though the literature in many MCO plans may state that beneficiaries may have "up to 20 sessions" in a year, often times the companies' reviewers are told never to allow more than a few sessions (see vignettes), or providers are warned that if they average more than a few sessions per patient, they will be ejected from the panel or refused further referrals. Thus, the provider may be too afraid to give the consumer the treatment that is needed.

e) A recent Harvard study (James Hegarty, MD, at McLean Hospital, Boston, as reported in *Newsday*, "Study: Managed-Care Squeezes Hospital Stay," 5/24/95) showed that there has been a dramatic increase in re-hospitalizations of psychiatric patients under managed care due to premature discharges. The average length of stay (LOS) at McLean in 1989 was 45 days. By 1994, due to managed care, the average LOS was 15 days. There was a concomitant increase in the number of people readmitted within a month, from 0% in 1989 to 21% in 1994, and an increase in patients who were minimally improved or worse at discharge than at admission, from 4% to 18%.

f) The industry is ignoring 100 years of development in the field of psychotherapy and is creating standards for treatment that are *substandard*.

5. Many managed care provider contracts contain "non-disparagement clauses," prohibiting the provider from saying anything negative about the managed care company to the patient or anyone else, often preventing providers from making the consumer aware that he/she is not receiving proper care.

Consumers are prevented from accessing professionals who follow their ethics and refuse to sign such agreements, as these providers will not be included on the MCO's panel. Also, this can mean that if a panel provider believes that the MCO's recommendations would be harmful to the patient, the provider may not tell this to the beneficiary. The consumer should have the right to know his/her provider's opinions of treatment decisions made by the MCO, especially if the provider believes that the MCO's decision is not in the patient's best interests. Also, these clauses prevent managed care abuses from reaching the press and legislators.

6. Patients may find that they must fight for benefits when they are ill, when their energy should be spent on getting well.

Patients never know whether or not their treatment will be covered until they become ill. Since providers may be at risk if they advocate for the consumer, this leaves consumers often having to spend their energy on advocating for themselves when needed treatment is being denied. Patients who do not have the ability, self-confidence, or energy to advocate for themselves may be seriously under-treated. Often, mental health patients are too derpressed, anxious, or too humiliated by their problems to advocate for themselves. With providers being at risk for unemployment if they advocate for their patients, there may be no one left to advocate for the elderly patient, especially if family is uninvolved or lives far away.

7. Under managed care, many providers fear doing what is right for the patient, putting the consumer at risk.

Since the MCO's now decide which providers will be able to continue working, many have been frightened into silence. Many feel too powerless to protest poor treatment of consumers to the MCO, the press, or to their legislators. When New York State's Assembly held hearings on managed care in January, 1994, several providers told me they were too afraid of being identified by the MCO's to testify. Their fear was that they would be ejected from the networks, refused referrals, or that their patients would be refused future sessions. These very real threats put the consumer at risk, especially in mental health, where patients usually do not advocate for themselves, and especially with the elderly patient, who may not be able to advocate for him/herself.

8. Quality and quantity of care will always be a problem under managed care and any form of capitation, as *there is an inherent conflict of interest when an entity that is supposed to offer care, be it an MCO or an individual provider, keeps whatever money is not spent on treatment.* This is especially destructive when mental health is under-capitalized.

a) MCO's keep money that is not spent on treatment. Corporate profits are soaring while beneficiaries are prohibited from receiving care for chronic and ongoing problems and are being discharged from hospitals prematurely.

b) Even capitated contracts that are made between employers and providers directly, bypassing MCO's, are problematic. One California therapist told me that she was called by a capitated plan and told that she would receive approximately $235 for each patient they send her. Obviously, if she performs one session only, she does very well. She still does well if she performs only two. Obviously, if the patient requires 10 sessions, she is receiving poor wages (with no benefits) for someone with a doctorate or even a master's degree. If the patient requires 40, 50, or more sessions, it becomes ludicrous. Thus, there is a strong incentive to under-treat, and clinicians may simply not be able to afford to

treat patients properly due to under-capitation. It is the bias of the corporations that people should only require 1-3 sessions. This is not reality.

c) It is true that under the fee-for-service system, there was some incentive to over-treat the patient. However, not all providers over-treated, as wise clinicians knew that they would receive future referrals from patients whom they treated appropriately. Also, under a fee-for-service system, if a consumer feels that he/she is not being treated properly, he/she can easily leave that clinician and find another. Further, a system of appropriate co-payments, when used by the insurers, encouraged consumers to be cost- and utilization-conscious.

9. Despite claims that managed care and managed competition comprise a "free market solution," there is no free market for the patient, the actual consumer of health care.

a) Managed competition is really about the elimination of competition. As consolidation continues, only a few large insurers will remain.

b) In several areas, the industry already controls 90% of the market. Where managed care squeezes out fee-for-service plans, *there is no competition for managed care itself.* A lack of competition always bodes poorly for quality.

c) A free market for the patient would mean that the patient is the one who would determine what care is needed, determine the value of that care, and choose freely from all who are qualified to provide that care. Managed care does not allow the patient these liberties. As managed care becomes an arrangement between employers or governments and the insurer, and the "consumer" becomes the employer or government, for they pay the premiums, the "free market" exists between the MCO and the payor. Under managed care, the MCO determines who will receive what kind of treatment, for how long, and who can deliver it. The true consumers of care, the patients, as well as the body of professionals who could administer care, are kept out of the "marketplace."

d) The managed care industry controls both supply and demand in regard to health care services. MCO's have declared that there is an over-supply of mental health professionals. This is predicated, however, on the industry's assumption that only brief forms of crisis-oriented therapy are needed, and that few people need treatment. This is not based upon true demand, which would be based upon the citizens' requests for care. Although fee-for-service is a "subsidized" market, it is still based on a more true supply and demand than under managed care. Under a fee-for-service system which had, in recent years, seen extremely high co-payments for psychotherapy, the demand for services was far greater than what is allowed under managed care. There will soon be a drastic shortage of mental health professionals and other providers, for the number will be based on what the managed care industry "needs," not upon what our citizens need. This will affect our entire society.

C) Recommendations:

1. Allow Medicare beneficiaries to choose among a variety of health plans, including fee-for-service plans, Medical Savings Accounts, MCO's, and any other type of health plan that currently exists or is yet to be devised.

a) Medical Savings Accounts (MSA) are attempts to return the rights of the "free market" to the actual consumers of health care. Incentives are provided that make the consumer cost- and utilization-conscious. Up to the catastrophic limit of the MSA, the consumer retains the right to choice of provider, the right to privacy, and the right to make his/her own treatment decisions.

b) There are some problems with MSA's, however:

i) Beyond the catastrophic limit, the consumer retains freedom of choice, but loses privacy and the right to make his/her own treatment decisions, as treatment may be subject to utilization review. However, because there are no panels, and MCO's can't threaten the providers with unemployment, providers are free to advocate for patients.

ii) The standard MSA contract written by the Golden Rule Insurance Company, has a limit on mental health services of $10,000 per year per individual. This is generally adequate for a patient requiring only psychotherapy, but not for one requiring a day treatment program or hospitalization.

iii) There is some concern that MSA's will not be appropriate for those who are unable to be responsible for their funds. This may affect some of the elderly. It may be necessary to arrange for a relative to make MSA decisions or, when there is no such relative close by, for a consumer case manager (not a case manager contracted by the insurer) to do so.

c) Some MSA plans are combined with MCO's. Again, this penalizes consumers for using out-of-network clinicians, which limits their choice of providers, especially for those with a limited income.

2. Return control over health care to the citizen:

a) Phase out employer involvement in health care. It no longer works. For employees, premium money actually belongs to the employee, for it is taken from his/her wages. Return this money to the employee so that employed citizens can purchase, own, and control their own health care plans. Under Medicare, and for citizens with limited incomes, beneficiaries should be expected to pay a portion of their premiums, based on their incomes, with government paying the balance.

b) Return the three basic rights consumers have lost under managed care (choice, privacy, and decision-making). Employees lost these rights because we now expect employers to pay for insurance, and because employers needed to cut costs once the patient became separated from the consequences of their decisions under the fee-for-service system. Citizens have been separated from the fact that it is their money to begin with, and the greater the separation, the less care they take with that money.

c) In order to protect their freedom, citizens must be financially responsible for their care to whatever extent they can afford to be so.

i) Medicare beneficiaries with adequate incomes would buy their own plans, or at least pay for a portion of their premiums. Government would pay that portion of the premium which is unaffordable for the Medicare beneficiary or other citizens.

ii) Benefit design must create incentives for patients to be cost- and utilization-conscious, without restricting access to care and other freedoms.

d) Individual mandates might be considered. Car insurance is required of all who drive, not just of all who have accidents. Why can't health insurance be required of all who live, not just those who get sick? While we might wish to protect the freedom of the citizen NOT to be insured, all citizens must then pay for emergency care and follow-up treatment when an uninsured individual requires treatment he/she cannot afford out-of-pocket.

3. Protect quality care and consumer freedoms by encouraging citizens to buy and own their own insurance plans. Allow a 100% tax deduction for all citizens buying their own health care plans.

All citizens deserve the tax break now given to employers, especially those who are self-employed or unemployed, which may include a large number of Medicare beneficiaries. Also, it is important for a government to encourage people to take care of themselves, so they will be less dependant upon the government for services. The more health insurance coverage one owns, the less dependent one will be on the government for care.

4. Guarantee portability of health care plans.

5. Prohibit "pre-existing condition" barriers to treatment.

6. Guarantee all citizens in MCO's access to "Point-of-Service" options:

Unfettered access to specialists is crucial for those who are ill.

7. Guarantee the right of all citizens, including Medicare beneficiaries, to "contract privately" with providers of their choice.

In the case that a health plan denies reimbursement for a particular service, the citizen must still be allowed to purchase health care he/she believes is necessary. The MCO might be making incorrect decisions. Medicare beneficiaries cannot currently purchase psychotherapy except from Medicare providers. If Medicare comes under managed care, beneficiaries will also frequently be denied more than a handful of psychotherapy sessions, as is already happening to the general population. Most MCO's are only allowing "crisis" care, and are prohibiting true forms of psychotherapy. We cannot make it *illegal* for Medicare beneficiaries, or anyone else, to obtain genuine psychotherapy.

8. Allow the States to regulate the managed care industry.

a) With a true "free market" system, in which the citizen has the ability to make his/her own health care decisions while being given incentives to be cost-conscious, there will be less need for regulation than there is under managed care.

b) Managed care plans frequently short-change the patient, and often prevent providers from advocating for patients and from delivering the best care they know how to

provide. It is imperative that the federal government allow the States to regulate this industry. ERISA laws were not intended for health care. They were intended for pension plans. If employer involvement were phased out, employers would not object to state regulation of health insurance plans.

9. Allow states the flexibility to experiment with a variety of health care plans.

a) Encourage the States and regions to develop insurance plans that involve "freedom with responsibility." MSA's attempt to do this.

b) There are many ideas yet to be devised and written down (e.g., see "Managed Cooperation," item F, below). Please do not lock Americans into any particular form of system, as this will prevent better ideas from being formulated and implemented.

D) Summary:

There are many problems that have already occurred in the private sector under managed care. These problems generally involve the loss of consumer freedoms to make their own treatment decisions, in private, with their chosen clinician. In mental health, the industry has changed the "standards of care" to substandard care.

In general, we urge Congress to institute some insurance reform and to allow the States to regulate the managed care industry. We urge Congress to increase choice of plan for Medicare beneficiaries and others, and to pass legislation that enables the development and implementation of programs that offer alternatives to managed care and managed competition, especially those that re-institute a true free market for the actual consumers of care. We support plans which retain consumer freedom while containing costs by providing incentives for consumers to be cost- and utilization-conscious, thus expecting some financial responsibility from the consumer, according to the financial means of the consumer.

E) Vignettes from Managed Mental Health Care - see pages 7 & 8.

F) "Managed Cooperation:" A Medical/Mental Health Care Plan - see pages 9 & 10.

These pages contain ideas ("Managed Cooperation") designed by the Coalition. Many of these ideas could be helpful in designing systems of cost-containment that put the consumer of care back in charge of his/her own treatment.

COALITION OF MENTAL HEALTH PROFESSIONALS AND CONSUMERS, INC.
P. O. BOX 438, COMMACK, NY 11725
PHONE/FAX: 516-424-5232

Original Vignettes (#1)
Managed Mental Health Care
(Revised 12/18/93)

The following vignettes are summaries of managed care (MC) cases. Decisions about who can be in treatment, how long treatment can continue, what type of treatment patients can have, and who can provide it, are being made by the MC companies. While they state they are basing decisions on "medical necessity," the companies cannot be free of a need to themselves be profitable. Unfortunately, the cases below are not atypical.

1. Ten year-old "Susie" was involved in a tragic and frightening accident. She and one parent escaped, but the other parent and her sibling died. "Susie" became mute, and began drawing pictures of a little girl with a noose around her neck. The surviving parent brought "Susie" to their HMO. "Susie" began therapy, but her pictures became increasingly darker (a symbolic indication of deepening depression and increasing suicidal risk). After the ninth session, the parent found "Susie" about to make a suicide attempt. This was reported to the therapist (who had not yet earned a master's degree) at the 10th session. This HMO therapist concluded treatment with the 10th session, stating that "Susie" "should be" finished. "Susie" was still mute and suicidal. Fortunately, the parent had some money available to pay for therapy without insurance coverage. The parent asked a friend for a referral outside the HMO and found a psychiatrist who offered a reduced fee. "Susie" was seen three times/week for 18 months. It took 12 months before "Susie" began to speak again.

2. "Mary," a depressed woman with several physical problems related to her emotional disorder, was denied therapy after 8 visits, even though her policy allowed up to 20 visits. The therapist (licensed) strongly recommended further treatment, but the reviewer (not licensed) refused authorization, saying that he had been instructed not to approve any outpatient treatment beyond 8 sessions regardless of the diagnosis or provider recommendation. "Mary" was too depressed to appeal. Within a month, she was hospitalized for severe gastric distress and required surgery. The therapist believes this was caused by inadequately treated depression.

3. "Jane," a depressed and suicidal woman, had finally left her physically abusive husband. She called her MC company for permission to begin therapy and for a referral. The request was refused. The reason given was that "domestic violence is a social problem, not a psychological problem."

4. "Sean," an adolescent boy, asked to be in therapy. His mother called the MC company for permission for him to begin therapy and for a referral. "Sean" stated he would not be comfortable seeing a male therapist. No list of network therapists is published, so the mother could not find an appropriate referral herself. The company agent refused to offer the name of a female therapist, though there were many in the network in that area. Despite many protests by the mother, the agent gave only names of male therapists, stating: "Listen, if you're sick, it doesn't matter who you see. And if you don't take the names I gave you, I can't help you anymore."

5. "Rosa," a young mother with 3 young children, cuts her wrists. Her HMO approved only 8 sessions. The therapist believes her symptom is due to feelings of anger at the responsibilities of motherhood. As the oldest of 9 children herself, "Rosa" had been over-burdened with responsibility as a child, for her own mother was unable to care for the children. Without appropriate treatment, "Rosa" will not likely understand the reasons for her distress. She will likely continue to cut her wrists, possibly escalating to serious cuts. The potential for child abuse is also present should "Rosa" begin directing her anger outward instead of toward herself.

6. "Henry," a middle-aged man with a childhood history of being severely humiliated, requested treatment due to interpersonal problems, including difficulty trusting others. "Henry" refused to return to treatment when the therapist was required to submit a detailed report about him and his therapy. The therapist finally convinced him to return and they spent much time discussing what the therapist should write. The report was written and more sessions were authorized, but "Henry" never returned for treatment. When the therapist called him, "Henry" said that the experience of having to divulge information to the company was too humiliating for him.

(over)

7. "Steven" experienced increasing depression, panic attacks, and phobic anxiety that prevented him from working. His psychiatrist provided psychotherapy and medication. There was a brief admission to a local hospital for a suicide attempt. After a year of treatment, "Steven's" insurance was changed to a MC company. The psychiatrist joined the network to be able to continue the treatment. The treatment resistant depression and severe anxiety showed some improvement, but the MC company said "Steven" was a "chronic" patient who wasn't showing enough improvement. The psychiatrist had to plead for more sessions. "Steven" did show more improvement. Later, a new anti-depressant helped lift "Steven's" mood and eliminated almost all panic attacks. However, "Steven" then began manifesting increasing manic symptomatology, including spending sprees. Restarting Lithium, which had been helpful in the past, now led to an organic brain syndrome. To be hospitalized under his MC plan, "Steven" would have had to enter the MC company's "anchor" hospital, which was not in his community, and would have been required to change psychiatrists. "Steven" refused to change psychiatrists and thus refused the hospitalization, though he would have agreed to a local hospitalization with his own psychiatrist. The organic symptoms decreased, but the manic symptoms remained. However, the psychiatrist did not feel "Steven" qualified for an involuntary hospitalization. "Steven" endured a full month of manic symptoms, including spending sprees. The cost to "Steven" was great in terms of financial, interpersonal and emotional effects before the manic symptoms remitted with outpatient treatment.

8. "Barbara" was in individual and group therapy before a MC company took over her insurance. She had been sexually abused by her grandfather in many horrifying ways between the ages of 5 and 12. She was also abused by a neighbor at age 12. Marital sex was accompanied by terrifying flashbacks of the abuse. The therapist was told by a reviewer to "hurry it along." Unfortunately, the symptoms had worsened because "Barbara" was given a new assignment at work which required her to work with men about the same age as her grandfather. Also, she had recently undergone her first gynecological exam, which left her psychologically disorganized for several weeks. The reviewer, a psychiatrist, asked if "Barbara" was suicidal. When the therapist said she was not, the reviewer disallowed further group treatment, stating she was just "following company policy." Group treatment, in addition to individual treatment, is often extremely important for sexual abuse survivors.

9. "Linda" was in treatment for about 1 1/2 years before a MC company took over. "Linda" was unable to tolerate anti-anxiety medication, but did respond to psychotherapy. Toward the end of the second year, "Linda" witnessed her 22 year-old daughter being hit by a car, leaving her a quadriplegic. "Linda's" symptoms increased dramatically. She was likely manifesting signs of Post Traumatic Stress Disorder. The therapist called the reviewer for permission to continue treatment. The therapist was told: "Well, doctor, let me tell you something. We are going to cut you off - be prepared - its coming down the pike soon!"

10. "Allison" had been sexually abused by two of her brothers for several years during childhood. She was raped as an adolescent, and battered throughout her first marriage. She was in group and individual therapy. Group therapy was later denied by the MC company. When the therapist, a recognized expert in treatment of sexual abuse, told the reviewer that the literature speaks to the importance of individual and group therapy for optimal treatment, the reviewer said: "Listen, we are not interested in providing optimal treatment. We are interested only in providing that which is absolutely medically necessary."

11. "Bill" is usually in control of his anger, but when he loses his temper, he threatens his pregnant wife with a loaded gun. His therapist was encouraged to complete the work in 8-12 sessions. Although the reviewer agreed this was a "long-term" case, he stated that it is not the company's policy to provide long-term treatment.

12. "Jennifer," in her late 30's, noticed pain in one breast, though she found no lump on self-examination. Her HMO doctor also found no lump. "Jennifer," suspecting a problem, asked for mammography. The doctor, who also acted as "gatekeeper," stated that the HMO does not pay for mammography for women under 50 unless there is a physical finding upon examination. With this refusal, "Jennifer" had a mammogram outside her HMO at her own expense. The test showed breast cancer. She decided to sue the HMO. Distressed by the cancer and the refusal of the HMO to provide the services she deemed necessary, "Jennifer" requested psychotherapy to deal with the stress. The HMO refused to authorize psychotherapy for her.

Coalition of Mental Health Professionals and Consumers, Inc.
P. O. Box 438, Commack, NY 11725 Phone/Fax: 516-424-5232

MANAGED COOPERATION

A Medical/Mental Health Care Plan

An idea for the future

(revised 2/14/95)

1. The success of a health care plan will depend on the value system upon which it is based. Cooperation seeks solutions that enhance and are fair to all parties involved.

2. Managed Cooperation optimally balances patient choice and freedom with responsiblility, instills provider responsibility to the patient, and engenders cost- and utilization-consciousness in patients and providers.

3. Managed Cooperation can be written in both single and multiple payer versions.

4. Benefit design would encourage patients and providers to be conscious of costs. When little or no co-payment is expected at the time of service, patients may not be motivated to question a provider's fees or suggested procedures. External controls (gatekeepers, case managers, and utilization reviewers) may then be called upon to do this, reducing patient control over their care. It is important, therefore, for patients to be financially responsible for their care at the time of service to the extent that out-of-pocket expenses are significant enough to the patient that the patient questions providers about fees and recommendations, but not to the point where out-of-pocket costs are burdensome and present a barrier to treatment for those with limited incomes. Sliding scales for premiums, fees and co-payments, deductibles, and catastrophic limits are all possibilities under Managed Cooperation.

5. We suggest a gradual phase-out of employer involvement in health care. When employers buy coverage, they may, understandably, seek to control the care given, limiting the freedom of citizens to make their own treatment decisions, in privacy, with their chosen clinicians. Since the money used by employers to buy insurance really comes out of the employees' income, we encourage a return of this money to employees in the form of income so that they may buy and own their own policies. This returns control over health care choices and decisions to the individual citizen. The possibility of an individual mandate might be considered.

6. Managed Cooperation relies upon regional cooperation. Cost-containment procedures as described below would be carried out by Regional Boards made up of consumer advocates, professionals, government representatives, and insurers (if a multiple payer plan is used).

7. Annually or every other year, Regional Boards would recommend fee ranges and insurance reimbursement levels for each procedure and send this information to consumers, clinicians, and insurers (the government if single payer systems are used or to insurance companies if a multiple payer system is used). Insurers would set dollar amounts for each procedure's reimbursement. Providers would set fees, preferably on a sliding scale, starting with a fee minimally above the reimbursement, up to a reasonable "full fee." The co-payment would be the difference between the reimbursement and the fee for the patient's income level, and could be legally waived if necessary. Clinicians would provide current and prospective patients with their fee schedule

upon request. The intention is to provide true discounts for those with limited incomes. The Board's recommended fee ranges would protect wealthier patients from being over-charged. High-priced clinicians would have to be able to justify their fees to patients. Caps on fees and the mandatory use of sliding scale fees could be instituted if a voluntary sliding scale did not adequately control fees. Sliding scales might be able to be used for hospital expenses if the percentage share for costs was graduated according to income (e.g., citizens earning $30,000 might only pay 5% of hospital bills up to a catastrophic limit appropriate for their income, while those earning $300,000 might pay 50% of all bills up to an affordable catastrophic limit.

Under this system: a) the insurer's liability is limited by the fixed reimbursement, b) patients and providers, due to a co-payment scaled to the patient's income, become cost- and utilization-conscious, c) patients could "comparison shop" and have freedom of choice, and d) practitioners would be guaranteed at least a minimum payment for each procedure (the fixed reimbursement), yet would retain some independence to compete in a truly free market based upon training, talent, reputation in the community, and fees.

8. Regional Boards could regulate purchases of expensive machinery; perform outcome studies; focus on fraud and incompetence, rather than micromanagement; and settle disputes between patients, providers, and insurers.

9. Government support for building hospital-based and free-standing primary care centers would reduce emergency room visits and encourage primary care use.

10. Outpatient psychotherapy would cover individual, group, and marital/couple/family treatment, as allowing children, adults, or families to remain in distress is harmful and costly to our country. Coverage for 40-50 sessions/year is recommended, as: a) 85% of patients use less than 26 sessions, even with liberal benefits and no UR (utilization review), b) liberal outpatient benefits reduce inpatient costs and, thus, overall mental health costs, and c) preventing the 15% of patients who need long-term psychotherapy from receiving it may increase society's costs and harm patients and their families. UR can be used to provide additional sessions beyond the annual limit for those who demonstrate strong psychological and/or medical need AND financial need. UR would not intrude on session content or personal information. Inpatient treatment would require UR, but at reasonable intervals. Medication management would be given the same status as any medical visit. Partial hospitalization, half-way houses, and group homes would be supported to reduce inpatient costs and the costs to society of inadequately treated mental health needs. There would be no limit to inpatient care for the seriously mentally ill (schizophrenia, bipolar disorder, major depression, severe borderline personality disorder, etc.), but appropriate UR would be utilized. Patient education would be developed to explain mental health problems, different forms of treatment and psychotherapy, and the educational requirements of different types of clinicians.

11. UR, or at least denials of benefits, would be done by licensed, practicing professionals who are independent of the insurer, and who have training comparable to that of the treating clinician. UR would focus only on those procedures known to be over-utilized.

12. Incentives in the form of partial premium rebates could be used to encourage patients to refrain from submitting smaller claims.

13. Claims procedures would be simplified and standardized, and claims could be submitted either by patients or providers.

TESTIMONY SUBMITTED FOR THE RECORD
CONSORTIUM FOR CITIZENS WITH DISABILITIES

MANAGED CARE AND PEOPLE WITH DISABILITIES

The 49 million people with disabilities in this country include individuals with physical and mental impairments, conditions or disorders, and people with acute or chronic illnesses which impair their ability to function. People with disabilities are disproportionately represented among the underinsured and uninsured in America's private health insurance system.

A sound managed care plan can offer several advantages to people with disabilities: well-coordinated care or case management; comprehensive services; the convenience of "one-stop shopping" which minimizes physical and other obstacles to obtaining care; and an emphasis on primary and preventive care. Unfortunately, these potential positive aspects of managed care are usually undermined by the economic incentives inherent in managed care and capitated health plans. Many of these incentives run counter to the interests of all beneficiaries, particularly people with disabilities and chronic health conditions. People with disabilities often have extensive, special, and complex health care needs and are often underserved in these types of plans.

Managed care plans would significantly decrease their costs over time if appropriate services were delivered to people with disabilities and chronic conditions in a timely manner. The provision of appropriate rehabilitation therapies, services, and devices today can substantially reduce secondary, expensive conditions tomorrow. The provision of home and community-based services, including personal assistance services, can greatly save expenditures on institutionally-based inpatient and long-term care. All health plans, particularly managed care plans, should consider their enrollees' long-term health status and seek to maximize their function and independence through primary and preventive care, appropriate rehabilitation therapies and services, and assistive devices and technologies. More often than not, managed care plans simply do not do this.

As managed care is increasingly utilized by both the private and public health care systems, it is imperative that consumer and provider safeguards are established and enforced under Medicare, Medicaid, and private managed care plans.

PROBLEMS WITH MANAGED CARE

Gatekeeper Inadequacies/Choice of Providers

Most managed care plans use "gatekeepers" to manage individuals' care. While in theory a gatekeeper provides coordination of care, in reality a gatekeeper can create many problems for people requiring frequent or specialized health care services. Due to financial disincentives, gatekeepers may delay access to critical services which people may need immediately. Gatekeepers may also be reluctant to refer patients to specialists because of utilization limits imposed by managed care plans, despite gatekeepers' unfamiliarity with the health care needs of people with specific conditions or disabilities or the medical needs of the chronically ill.

People with disabilities often require specialists with whom the managed care plan may not have a contractual relationship. Another common problem is that of insufficient numbers of specialists in the panels of some managed care plans, leading to long waits for appointments.

Many managed care plans assign enrollees to physicians and do not allow subscribers to choose their own physician who may be familiar with their medical history and health care needs. In addition, most plans do not allow specialists to serve as a gatekeeper. However, many people with disabilities, because of their complex requirements, often need a specialist to meet their primary care needs and to determine if additional specialized services are needed. Children with disabilities often need the option of pediatric specialists as the primary physician or as part of a multi-disciplinary team. In some managed care plans, children with disabilities may be limited to adult specialists who may not be familiar with the special needs of children.

Inadequate Benefits

A comprehensive benefits package is critical for people with disabilities, but all too often managed care and other private insurance benefit packages are based on an acute care model. For example:

- Managed care plans typically cover only 60 days of rehabilitation and sometimes provide no rehabilitation services at all.

- Managed care plans rarely cover home and community-based health care services, such as home nursing and personal assistance services, which often prevent multiple re-admissions to acute care settings.

- Managed care plans often have annual and lifetime caps for certain conditions or treatments (usually mental health and substance abuse)

- Enrollees are often denied benefits based on narrow definitions of "medical necessity" because these definitions are based on the health care needs of the "average" person. For example, managed care plans often refuse to authorize physical therapy for people with chronic conditions because such therapy would "maintain" rather than "improve" function.

- Many plans refuse coverage of durable medical equipment, orthotics and prosthetics (orthopedic braces and artificial limbs), and certain therapies, such as respiratory and recreation therapy, which are important to maintain function and prevent secondary complications.

- Definitions of durable medical equipment and prosthetics/orthotics are often restrictive. This is a particular problem for individuals requiring customized medical equipment, such as specialized wheelchairs and seating systems, and most types of orthotics and prosthetics, which require specialized expertise and custom fitting and fabrication to the unique needs of each patient.

- Drug formularies or other restrictive lists of covered pharmaceuticals are commonly used by managed care plans. For some people with disabilities and chronic conditions, particularly people with rare disorders, effective drug therapies may not be available in managed care plans.

Access to Centers of Specialized Treatment

Some people with disabilities require highly specialized providers who may not participate in a managed care plan's network. Furthermore, continuity of providers is critical to people with special health care needs who require specialized care sporadically over time. Some people with chronic conditions, including individuals with mental illness, sustain great harm when forced to disrupt existing relationships with providers.

Many people with severe or rare conditions can often only receive appropriate care at highly specialized centers which may be affiliated with schools of medicine or teaching hospitals, or may be free-standing centers with specialized treatment expertise. Examples of these conditions include certain neurological and rare disorders, intractable pain, and a number of orthopedic impairments requiring specialized assistive technology. Many managed care plans will not cover care received at these centers.

Incentives to Underserve

Many managed care plans, particularly capitated plans, have built-in incentives to underserve patients which can place persons with disabilities at significant risk. They may --

- pay nonsalaried physicians according to the numbers of patients served, which leads to insufficient time and attention being paid to individual patients;

- provide bonuses or penalties to providers based on their adherence to utilization limits determined by the managed care plan;

- place individual physicians at financial risk for caring for patients by requiring physicians to assume the cost of out-of-plan specialty care.

RECOMMENDATIONS

Managed Care Safeguards for Consumers and Providers

To address these significant problems with health care delivery through managed care, Medicare, Medicaid, and private health insurance reforms should include safeguards for consumers and providers from certain managed care practices. Managed care plans continue to gain market power with few federal or state guidelines for the provision of quality care, particularly for people with disabilities and those with specialized or complex health needs. Managed care plans should at least be required to meet certain standards to maintain access, quality, and accountability to enrollees. Without these protections, managed care plans can be devastating to the health status and ability to function of people with disabilities and chronic health conditions.

CCD strongly encourages the 104th Congress to include the following provisions in any proposals to reform both the public and private health insurance systems. These provisions have wide support in the consumer and provider communities.

- **Consumer and Provider Due Process Protections**

  CCD strongly supports the inclusion of due process protections in Medicare, Medicaid, and private insurance reform legislation so that consumers and providers are on a level playing field when interacting with powerful managed care companies. These protections will ensure appropriate decision-making and selection procedures for providers, and in so doing, will protect consumers in their choices and access to health and mental health professionals and other providers.

- **Quality Assurance Provisions in Managed Care Plans**

  The need for appropriate quality assurance measures is particularly important for people with disabilities and chronic conditions in managed care settings. As enrollment in managed care health plans continues to increase, consumers must be informed about the nature of managed care health delivery and their rights within these plans. Consumer needs must be routinely and systematically considered and consumers must play a central role in decision-making within the managed care entity. In fact, consumer involvement is critical at all levels of health care system governance. CCD strongly supports an emphasis within public and private health plans on consumer choice, consumer involvement in the governance of the plan, consumer rights, and consumer satisfaction. We believe that this emphasis on the role of the consumer is directly related to assuring the actual quality of health and health-related services provided under managed care plans.

- **Point-of-Service Option**

  Managed care plans should provide a point-of-service option to their enrollees in order to allow persons with specialized health care needs to obtain care from out-of-network providers, assuming they opt to pay the extra premium and copayments necessary. This provision retains the ability of closed-panel HMOs to contain costs but also allows enrollees the flexibility to opt out of the network if they pay a little more for this option.

- **Specialists as Gatekeepers**

  Enrollees in network plans who require ongoing, specialized health services should be able to choose a specialist to act as their gatekeeper and to manage their condition. Relevant physician and non-physician specialists should also be directly available to enrollees without gatekeeper approval where continued specialized care is medically indicated. For instance, a person with spinal cord injury should be able to access a qualified physiatrist as a gatekeeper who would provide primary care at the primary care reimbursement rate and specialty care at the specialist rate. Similarly, a person with multiple sclerosis should be able to choose a neurologist as a gatekeeper who has authority to refer to non-physician providers of specialty care in order to manage a chronic condition over time.

- **Health Plan Arrangements with Providers**

  All health plans should enter into agreements and other arrangements to ensure an appropriate mix, number, and distribution of qualified health professionals in order to adequately provide the plan's benefit package.

- **Access to Specialized Treatment Centers**

  Managed care plans should ensure access to academic and other specialized health centers. CCD recognizes that much specialized health expertise is provided in centers that are not academically affiliated. Provision should be made in any legislation addressing health care issues to provide people with disabilities and chronic illnesses requiring specialized care access to a variety of centers of specialized treatment expertise.

- **Utilization Management Protocols and Physician Incentive Plans**

  Utilization review should be performed by qualified personnel with knowledge in the specific medical area in which the coverage decision is being made. Physician incentive plans can be extremely harmful to enrollees who require significant and/or ongoing health services due to the incentives to underserve inherent in these arrangements. In fact, all incentives to underserve managed care enrollees, financial or otherwise, should be prohibited.

Any legislation addressing the public or private health care system should include all of these important provisions.

For additional information, please contact one of the CCD Health Task Force Co-Chairs on the cover page of this testimony.

STATEMENT OF CONGRESSMAN BILL LUTHER (MN-06)
WAYS AND MEANS SUBCOMMITTEE ON HEALTH
5/24/95

Mr. Chairman:

I seek to testify today on an issue that affects many Americans, especially the citizens of states like Minnesota -- the issue of regional disparity in reimbursement for Medicare risk contracts.

I come from Minnesota, a state which is working hard to implement health care reform. For a number of reasons including efficiencies we have achieved along with bi-partisan efforts such as our MinnesotaCare health reform initiative, the people of our state enjoy among the lowest health care costs in the country while receiving excellent care. But ironically, we have been penalized by our efforts to become more efficient. Our health plans offering managed care to Medicare enrollees get reimbursements well below the average and, as a consequence, our Medicare beneficiaries are required to pay more out of pocket for less benefits than those in many other states.

The problem stems from the capitation rates under the TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) risk contracting programs, which serve approximately three million Medicare beneficiaries. Every year, HCFA calculates the capitation rate, called the Adjusted Average Per Capita Cost (AAPCC), which is the amount a health plan receives to provide Medicare coverage. This figure, however, varies widely from county to county, and herein lies the problem. This rate is calculated by first estimating a national average Medicare expenditure per beneficiary. HCFA then adjusts the rate to take into account the local trends in expenditures as well as the demographics of each particular area.

In Minnesota's case, our capitation rates are 70-80% of the average in urban areas. The 1995 Medicare payment rate per person in Anoka County, Minnesota is approximately $338. Since the rate is based on fee-for-service costs in each geographic region, and because our health care is delivered cost-effectively, our rate is lower. In states which have less effective health care systems, more money is spent per beneficiary. In calculating rates for these areas, HCFA figures a higher projected Medicare spending rate per beneficiary and capitation rates are higher. For example, the 1995 Medicare payment rate per person in Kings, New York is approximately $646.

The unfairness in this disparity is obvious. States that are keeping costs down are punished with low reimbursement rates, while those that have not controlled health care costs are rewarded with high per-person allowances. This inequity becomes even more glaring for beneficiaries of managed care plans. Because TEFRA requires that additional savings from managed care be passed to beneficiaries only as benefits, plans in areas such as Kings are able to offer more benefits yet cut out-of-pocket expenses such as premiums, deductibles and co-payments and still maintain a profit, while plans in states like Minnesota cannot afford to offer such benefits. Therefore, while people pay the same amount into Medicare during their working careers regardless of their state, some Medicare beneficiaries pay less and get more of their expenses covered than others depending simply on where they live.

Mr. Chairman, this is unfair and it is creating exactly the wrong incentive in the delivery of health care. We must adopt a new formula for setting Medicare reimbursement rates. If we are to achieve Medicare savings and yet serve the real needs of the senior population, the federal government must send a clear message. Rather than penalize reform, we must reward the efficiencies realized in a health care system like those in Minnesota. While the issue of reimbursement disparity is but one piece in the larger puzzle of Medicare, it is one that affects citizens all around the country and it has the potential to affect them dramatically in the future. It is time that the Medicare debate include discussions of efforts to achieve an improved Medicare system with a sound financial future. I look forward to working with you and other Members of the Subcommittee to address this issue.

Thank you.

TESTIMONY OF THE PATIENT ACCESS TO SPECIALTY CARE COALITION

Mr. Chairman: This statement is made on behalf of the Patient Access to Specialty Care Coalition ("Coalition"), consisting of nearly 100 patient, physician and non-physician health care professional organizations dedicated to ensuring the right of patients to consult and be treated at a reasonable cost by the specialist of their own choice, regardless of the health plan in which they are enrolled.

PATIENT CHOICE MUST REMAIN PARAMOUNT IN MANAGED CARE HEALTH CARE DELIVERY

As the presence of managed care increases in the marketplace, and as Congress seeks to further expand the role of managed care in the Medicare program, it is the Coalition's belief that Congress must preserve the patient's right to select the provider of his or her choice.

Many major changes are now taking place in the way people purchase health insurance and receive medical care. The pressures to reduce health spending continue to be intense, and health plans and providers have become more aggressive in their cost containment activities. While many health plans have developed a number of effective techniques to achieve economy and maintain quality of care, others have not always achieved that balance.

In this rapidly changing health care delivery environment, the Patient Access to Specialty Care Coalition believes that consumers of medical services must have effective protection against the potential that their access to medically necessary health care services will be inappropriately structured.

The most effective check against this potential restraint is the patient's power to seek and obtain medical services outside the provider network established by the health plan. Health plans that provide good service to their enrollees should not be troubled by this point-of-service feature. Only health plans that fail to meet the needs of their subscribers should be concerned.

THE POINT-OF-SERVICE FEATURE

The Coalition's message is a simple one. There are a number of current practices, especially in managed care settings, which impede patient access to treatment, particularly specialty care.

True freedom of choice for patients can only be achieved by making available out-of-network medically necessary treatment and services for all health care plans. All patients should have the option, at an additional but not prohibitive copayment, to seek the out-of-network treatment they desire. This feature should be built into every health care plan, and not just offered at the time of enrollment.

While offerring a point-of-service feature at the time of enrollment is a good first step in preserving consumer choice, patients sometimes act with less than perfect information when choosing a health care plan. Many times healthy patients are unable to assess their health care needs, until they actually get sick or need specialty care. Consequently, the broadest possible patient protection is to build choice of health care provider into every health care plan.

Real health security is the freedom for patients to choose their own physicians or specialty care provider, and then to continue to access these same caregivers regardless of a change of jobs or health care plans.

As Congress explores the role of managed care in controlling health care costs, it also has the opportunity to guarantee the patients' right to choose, and to make

consumers secure in knowing that the health care provider of their own choice will always be there.

Making available out-of-network treatment and services for enrollees in all health care plans provides a very good quality assurance check. It ensures that all health care plans provide the health care that their enrollees need and deserve. The ability of all Americans to seek out-of-network coverage, provides consumer protection as well. If a patient is not satisfied with care, he or she could pursue other treatment for a reasonable, but not cost-prohibitive price.

Today, one of the more popular health insurance products among consumers is a closed panel managed care plan with the availability of out-of-network coverage. Patients have been demanding this freedom to choose, and the marketplace has responded. This point-of-service feature for all health plans, therefore, is not intrusive, but rather advances a developing trend, and builds in consistency and predictability for consumers.

THIS POINT-OF-SERVICE FEATURE IS NOT COSTLY

Building a point-of-service feature into all health plans will not affect any health plans' ability to be aggressive in their cost containment activities, nor will it limit their efforts to encourage providers and consumers to use health care resources wisely. It will simply put pressure on health plans to keep patients' welfare uppermost on their agenda, ahead of dividends and the bottom line.

Consumers expect to bear some additional cost for this point-of-service feature. However, this cost is not great, and it is a simple actuarial calculation to determine a reasonable copayment. There is also no financial burden placed on the HMO.

The Patient Access to Specialty Care Coalition retained the firm of Milliman & Robertson, Inc. to study the cost impact on HMOs, if all closed-panel HMOs had to offer a point-of-service to their enrollees. A closed-panel HMO only allows patients to receive care from its own contracted providers. When a closed panel HMO has a point-of-service feature, patients have an opportunity to "opt-out" of the managed care's network of providers, and seek "out-of-network" care.

The managed care industry has consistently claimed that a point-of-service feature in all health plans would greatly increase the cost of doing business. This assertion is contradicted by the Milliman and Robertson findings.

According to this study, a built-in point-of-service feature for all managed care plans would not greatly change the cost of managed care or HMO benefits. In fact the study demonstrates that this point-of-service feature, in some instances, can actually lower the costs to an HMO.

The Milliman and Robertson study estimated the "net claim cost" for two typical health care plans in today's marketplace. These plans were developed from existing data in the HMO Industry Study, 1994 of the Group Health Association of America. Milliman and Robertson concluded that when it compared a point-of-service feature to a pure HMO (a closed panel), the expected cost ranged from a decrease of about 5 percent for a typical HMO plan to an increase of about 10 percent for a more generous HMO plan.

Analysis of this data demonstrates that the inclusion of out-of-network coverage within an HMO design does not, in itself, either increase or decrease claims costs incurred by the HMO. Instead, claims costs are increased or decreased depending upon the HMO's selection of factors (deductibles, copayments, and out-of-pocket limits)

that encourage or discourage utilization of out-of-network coverage and the nature of the discounts negotiated with network providers. (For the Subcommittee's use, the Coalition has shared with it a copy of the complete Milliman and Robertson study).

Again, the Patient Access to Specialty Care Coalition maintains that a built-in point-of-service feature provides a good safety valve for the unhappy or dissatisfied members of the closed panel HMO. Under the point-of-service feature, patients are able to go to a non-network provider of their choice. In doing so, however, the patient would incur a higher copayment for the opportunity to go "out-of-network."

This point-of-service feature provides the patient with an out when they question the quality of care they are receiving by the network's limited providers. It also provides an opportunity for the patient to seek an additional opinion from a non-partisan provider when the patient or family disagrees with the decision made by the closed panel HMO or the primary care gatekeeper to withhold treatment or deny an appropriate referral to a specialist.

EXPANSION OF MANAGED CARE IN THE MEDICARE PROGRAM

The Coalition is not opposed to managed care. It is concerned, however, that Congress may be embracing a concept of cost savings of managed care in the Medicare population without sufficient data.

Should Congress choose to go forward with expanding managed care in the Medicare program, the Coalition maintains that its recommended point-of-service feature will:

a) End the uncertainty and unpredictability of seniors moving in and out of health plans through open enrollment and disenrollment--the feature will always be there, and actuaries could easily calculate utilization of out-of-network services.

b) Give the Medicare patient effective protection against the potential for restricting access to medically necessary health care services.

c) Provide a quality assurance check on all health care plans to make sure that they are providing the full range of health care services to their enrollees.

THE POINT-OF-SERVICE FEATURE IS NOT AN "ANY WILLING PROVIDER" PROVISION

The point-of-service feature endorsed by the Patient Access to Specialty Care Coalition, differs substantially from "any willing provider" proposals. "Any willing provider" provisions deal with the contractual relationships between health plans and providers of medical services. The focus of the Patient Access to Specialty Care Coalition is on patient choice and the health care access rights of consumers and patients.

Mr. Chairman, the Patient Access to Specialty Care Coalition's point-of-service feature allowing patients to access out-of-network medically necessary care ensures real choice and real consumer protection, and is a sound quality assurance check to make certain that all plans offer the full range of quality health care.

In your continuing deliberations on managed care and the expansion of managed care in the Medicare program, we urge your Subcommittee to ensure adequate patient

protection and safeguards in this changing marketplace by instituting a point-of-service feature in all health plans.

A listing of the current membership of the Patient Access to Specialty Care Coalition follows:

Allergy and Asthma Network•Mothers of Asthmatics, Inc.
American Academy of Allergy and Immunology
American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology - Head and Neck Surgery
American Academy of Pain Medicine
American Academy of Physical Medicine & Rehabilitation
American Association for Hand Surgery
American Association for the Study of Headache
American Association of Clinical Endocrinologists
American Association of Clinical Urologists
American Association of Hip and Knee Surgeons
American Association of Neurological Surgeons
American Association of Private Practice Psychiatrists
American College of Cardiology
American College of Foot and Ankle Surgeons
American College of Gastroenterology
American College of Nuclear Physicians
American College of Obstetricians & Gynecologists
American College of Osteopathic Surgeons
American College of Radiation Oncology
American College of Radiology
American College of Rheumatology
American Diabetes Association
American EEG Society
American Gastroenterological Association
American Lung Association
American Orthopaedic Society for Sports Medicine
American Pain Society
American Podiatric Medical Association
American Psychiatric Association
American Psychological Association
American Rehabilitation Association
American Sleep Disorders Association
American Society for Dermatologic Surgery
American Society for Gastrointestinal Endoscopy
American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Clinical Pathologists
American Society of Dermatology
American Society of Echocardiography
American Society of General Surgeons
American Society of Hematology
American Society of Nephrology
American Society of Pediatric Nephrology
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Pediatrix Medical Group: Neonatology and Pediatric Intensive Care Specialists
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